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**UNIVERSAL FINANCIAL PROTECTION THROUGH NATIONAL HEALTH
INSURANCE: A STAKEHOLDER ANALYSIS OF THE PROPOSED ONE-TIME
PREMIUM PAYMENT (OTPP) POLICY IN GHANA**

A DISSERTATION SUBMITTED TO
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(SPECIALISING IN HEALTH ECONOMICS) DEGREE

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Universal financial protection through national health insurance: A stakeholder analysis of the proposed one-time premium payment (OTPP) policy in Ghana

A dissertation submitted to the University of Cape Town,
South Africa, in partial fulfilment for the award of a
Masters in Public Health (Specialising in Health Economics) Degree

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Declaration

I, Gilbert Abotisem Abihiro, hereby declare that this dissertation is an original work (except where acknowledgements indicate otherwise) produced by me under the supervision of Professor Diane McIntyre. Neither the whole nor any part of this work has been submitted or is intended to be submitted for the award of another degree in this or any other institution.

I have used the Harvard convention for citation and referencing. Each contribution to, and quotation in, this dissertation from the work(s) of other people has been attributed, and has been cited and duly referenced. RefWorks referencing software was used. For the journal article, the RefWorks' output was edited to reflect the journal requirement.

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Student -----

Date-----

Dedication

This work is dedicated to the loving memory of my very good friend, the late Ephrem Akeliselisa Ayamga from Sirigu, Upper East Region, Ghana.

Abstract

Extending coverage to the informal sector is a key challenge to achieving universal coverage through contributory health insurance schemes. Ghana introduced a mandatory National Health Insurance scheme in 2004 to provide financial protection for both the formal and informal sectors through a combination of taxes and annual premium payments. As part of its election campaign in 2008, the current government (then in opposition) promised to make the payment of premium 'one-time'. This has been a very controversial policy issue in Ghana. This study sought to contribute relevant information to assess the feasibility of the proposed policy by exploring the understandings of various stakeholders of the policy, their interests/concerns, potential positions, power and influences on it as well as the general prospects and challenges for its implementation. The data was gathered from a review of relevant documents in the public domain, 28 key informant interviews and 6 focus group discussions with key stakeholders in Accra and two other districts. The results show that there is a lot of confusion in stakeholders' understanding of the policy issue and because of the uncertainties surrounding it, most powerful stakeholders are yet to take clear positions on it. However, stakeholders raised concerns that revolved around issues such as: the meaning of one-time payment within the context of an insurance policy, the affordability of the one-time premium, financing and sustainability of the policy as well as the impact of such a policy on equity in overall access to health care. Policy-makers therefore need to clearly explain the meaning of the one-time premium policy and how it will be funded and critically consider the concerns raised by stakeholders before proceeding with further attempts to implement it. For other countries planning universal coverage reforms, it is important that the terminology of their reforms clearly reflects policy objectives.

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The ultimate glory goes to the Almighty God, my Lord Jesus Christ and the Holy Spirit for making this dissertation a success.

¹ The Kassena-Nankana East Health Centre is located in the recently created Kassena-Nankana West District, which was carved out of the then Kassena-Nankana District.

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List of acronyms/abbreviations

AIDS.....Acquired Immunodeficiency Disease Syndrome

ANC.....Ante-natal Care

AU.....African Union

CBHIS.....Community-Based Health Insurance Schemes

CEO.....Chief Executive Officer

CHI.....Contributory Health Insurance

CSOs.....Civil Society Organisations

DMHIS.....District Mutual Health Insurance Schemes

DRGs.....Diagnostic-Related Groups

FGDs.....Focus Group Discussions

GH¢.....Ghana (New) Cedi

GDP.....Gross Domestic Product

GHS.....Ghana Health Service

<i>GSS</i>	<i>Ghana Statistical Service</i>
<i>HIV</i>	<i>Human Immunodeficiency Virus</i>
<i>IGF</i>	<i>Internally Generated Fund</i>
<i>ILO</i>	<i>International Labour Organisation</i>
<i>ISSER</i>	<i>Institute of Statistical Social and Economic Research</i>
<i>KNWD</i>	<i>Kassena-Nankana West District</i>
<i>LMICs</i>	<i>Low-and Middle-Income Countries</i>
<i>MP</i>	<i>Member of Parliament</i>
<i>MOH</i>	<i>Ministry of Health</i>
<i>MDF</i>	<i>Management for Development Foundation</i>
<i>NDC</i>	<i>National Democratic Congress</i>
<i>NGOs</i>	<i>Non-governmental Organisations</i>
<i>NPP</i>	<i>New Patriotic Party</i>
<i>NHI</i>	<i>National Health Insurance</i>
<i>NHIA</i>	<i>National Health Insurance Authority</i>
<i>NHIF</i>	<i>National Health Insurance Fund</i>
<i>NHIL</i>	<i>National Health Insurance Levy</i>
<i>NHIS</i>	<i>National Health Insurance Scheme</i>
<i>NPV</i>	<i>Net Present Value</i>
<i>NSHIF</i>	<i>National Social Health Insurance Fund</i>
<i>ODA</i>	<i>Overseas Development Agency</i>
<i>OOP</i>	<i>Out-of-pocket</i>

<i>OTPP</i>	<i>One-time Premium Payment</i>
<i>PCIS</i>	<i>Private Commercial Insurance Schemes</i>
<i>PI</i>	<i>Principal Investigator</i>
<i>PMHI</i>	<i>Private Mutual Health Insurance</i>
<i>RAs</i>	<i>Research Assistants</i>
<i>SAP</i>	<i>Structural Adjustment Programme</i>
<i>SAZA</i>	<i>South Africa and Zambia</i>
<i>SID</i>	<i>Supplier-Induced Demand</i>
<i>SIDA</i>	<i>Swedish International Development Cooperation Agency</i>
<i>SHI</i>	<i>Social Health Insurance</i>
<i>SSNIT</i>	<i>Social Security and National Health Insurance Trust</i>
<i>TBF</i>	<i>Tax-based financing</i>
<i>TUC</i>	<i>Trade Union Congress</i>
<i>UC</i>	<i>Universal Coverage</i>
<i>UCT</i>	<i>University of Cape Town</i>
<i>UNICEF</i>	<i>United Nations International Children and Education Fund</i>
<i>VAT</i>	<i>Value Added Tax</i>
<i>WHO</i>	<i>World Health Organisation</i>

Part A: The study protocol

Word count=7,689 excluding references

1. Background

1.1. Introduction to health care financing and universal coverage (UC)

A key goal of health systems is to ensure that adequate financial resources are made available in order to provide sufficient access to needed health services for all residents (WHO 2007). This is done through the processes of revenue collection, resources and risk pooling, purchasing, and the provision of services (Kutzin 2001). Direct out-of-pocket payments and prepayment mechanisms are the main instruments for financing health care (McIntyre 2007). Out-of-pocket (OOP) payments include: user fees charged at public health facilities, full fees paid to private health care providers, and co-payments and deductibles paid by members of an insurance scheme (McIntyre 2007). Out-of-pocket payments are regressive, they do not involve risk pooling and they often lead to catastrophic health care expenditure (Arhin-Tenkorang 2000, Xu 2003, McIntyre 2006). Hence, they are not effective in providing financial protection against health care costs as compared to prepayment mechanisms (WHO 2005b). Prepayment mechanisms are means through which people contribute regularly either through taxes or insurance premiums towards the cost of health care (McIntyre 2007). Those prepayment systems that are progressively structured and involve risk pooling have been acknowledged as the most powerful means of attaining universal coverage in health care (Carrin, James 2004, Carrin, Evans & Xu 2007, WHO 2010).

Universal coverage in health care entails achieving universal financial protection and equitable access to needed services by residents (Kutzin 2007, McIntyre, Kutzin 2010). To move towards universal financial protection requires that all individuals and households are protected against the impoverishing consequences of out-of-pocket payments for health care at the point of illness (Arhin-Tenkorang 2000, McIntyre 2007, McIntyre, Kutzin 2010).

Apart from a few countries such as Germany, Japan, Korea and Thailand which have attained universal coverage (Carrin, James 2004, Evans 2007, Tangcharoensathein et al. 2011), many low-and middle-income countries with very large informal sectors are finding it difficult to arrive at the destination of universal coverage (McIntyre 2007, WHO 2005a, Samson 2009).

1.2. The historical context of health care financing in Ghana

Ghana is a lower-middle- income country with a very large informal sector which has over the years implemented several different health care financing mechanisms - all in the search for an appropriate strategy of providing needed health care to its residents. Mechanisms for financing health care in Ghana have since the colonial era seen several transformations corresponding with changes in political and economic conditions. As a strategy of limiting expenditure, health care was financed through direct out-of-pocket payment in the form of hospital fees (user fees) in the colonial era (Arhinful 2003). This however restricted access to modern health care services to only a small number of colonial elite and urban dwellers (Arhin-Tenkorang 2000, McIntyre et al. 2008).

The first post-colonial government in 1957, rooted in a socialist ideological orientation, however, introduced “free health care” for all Ghanaians at all public health facilities. This was done through the removal of user fees so that health care was virtually fully financed from tax revenue and donor funding (Nyonator, Kutzin 1999, Ramachandra, Hsiao 2007). The objective of the government was to remove financial barriers to access and provide financial protection against catastrophic health expenditure for all Ghanaians. This could be described as the first attempt in the history of Ghana at achieving universal financial protection through the implementation of a predominantly tax-based prepayment system. However, there was no specific dedicated allocation of tax revenue for health care and as a result the health sector had to compete with other sectors for the same government revenue

(MOH 2004). Hence, upon the overthrow of the socialist government in 1966, coupled with the onset of economic recession in the 1970s, it became increasingly difficult to sustain a purely tax-funded health care system.

By the early 1970s therefore, nominal user fees were introduced in public health facilities as a way of limiting “unnecessary use”. However, an increased severity of economic stagnation which led to the adoption of a World Bank and IMF Structural Adjustment Programme (SAP) in 1983 led to the introduction of high user fees at the point of service, famously known as the “cash and carry” system in 1985 as an attempt to recover at least 15% of recurrent expenditure on health care (Agyepong, Adjei 2008). Though MOH (2001) reports that the financial aim of the policy was attained, it resulted in inequities in access to health care; a decline in utilisation of services by about two-thirds and an increase in self-medication (Asenso-Okyere et al. 1998). Though exemptions from the payment of user fees were introduced for the very poor and other vulnerable groups, such exemptions were not effectively implemented (Nyonator, Kutzin 1999, MOH 2004, Nyonator et al. 1996, Garshong et al. 2001). The introduction of user fees (OOP) therefore meant that the poor no longer had financial protection against the cost of health care and hence were very vulnerable to catastrophic health care expenditure.

This again led to the search for an alternative financing mechanism that would guarantee poor households financial protection against health care spending at the time of using services. The only financing mechanism that had not yet been tested on a large scale in Ghana by then was contributory health insurance. In the 1990s, therefore, several community-based health insurance schemes (CBHIS) emerged in an attempt to replace out-of-pocket payment for health care (Sulzbach 2008). The Nkoranza Health Insurance Scheme introduced in 1992, a proposed SHI scheme by the Ministry of Health (MOH) for the formal sector and organised

groups such as cocoa farmers which was abandoned by 1999, and the Dangme West CBHIS introduced in 2000 were among the popular schemes of the 1990s (Agyepong, Adjei 2008). The often cited constraints of these schemes were that they covered only about 1% of the Ghanaian population (Atim et al. 2001) and hence the risk pools were limited and fragmented. This basically threatened the sustainability of the CBHIS. However, their existence served as an experimental basis for testing the feasibility of attaining universal coverage through contributory health insurance.

As Ghanaians approached another democratic political election in 2000, the major challenge to health care financing remained how to ensure that all Ghanaians have access to affordable health care in an equitable, efficient and sustainable manner. This issue became central to the political campaigns of the then opposition New Patriotic Party (NPP) as it promised to offer all Ghanaians universal access to affordable health care through the introduction of a health care financing system that would replace the regressive “cash-and-carry” system should it be voted into power. To deliver on its election campaign promise, the NPP government of Ghana that won the 2000 general elections took a bold step towards achieving universal coverage by introducing a mandatory National Health Insurance Scheme (NHIS) to replace out-of-pocket payments for health care (MOH 2004).

1.3 The National Health Insurance Scheme (NHIS) of Ghana

The National Health Insurance Scheme of Ghana, the first of its kind in Sub-Saharan Africa, was established by the National Health Insurance Act, 2003 (Act 650) and launched in 2004 by the Government of Ghana (MOH 2004, Government of Ghana 2003). With the goal of providing equitable and universal access to health care for all Ghanaians, the scheme was designed to incorporate both the formal and informal sectors by fusing both elements of a social health insurance (SHI) and community-based health insurance (CBHIS). The

legislation made it possible for the operation of three types of insurance schemes in order to offer all Ghanaians the opportunity to belong to the one of their choice (GHS 2004). These are: District Mutual Health Insurance Schemes (DMHIS) in all the 145 districts of Ghana; Private Mutual Health Insurance (PMHI) and Private Commercial Insurance Schemes (PCIS). It is however, only the DMHIS that are entitled to government subsidies. The DMHIS are district-based and each covers informal sector workers, formal sector employees and indigents. The National Health Insurance Authority (NHIA) was established to regulate and coordinate the operations of the various components of the scheme.

In terms of resource mobilisation, the scheme reflects a mixed system of contributory insurance and tax-based funding. It is funded from the following sources. First is annual premium contributions from informal sector workers and those formal sector employees who are not covered under the Social Security and National Insurance Trust (SSNIT) pension scheme. The contributions are supposed to be structured from GH¢ 7.20 for the lower to GH¢ 48 for the higher socio-economic groups respectively (McIntyre et al. 2008, D'Almeida, Durairaj & Kirigia 2010). However, because of difficulties in assessing household income levels, many DMHIS have fixed the premium at a flat rate. All children less than 18 years of age, indigents (poor), elderly (70+), and formal sector SSNIT contributors and pensioners are exempted from these premium payments (Agyepong, Adjei 2008, Asenso-Boadi, Agbeibor 2010). Second, is a 2.5% National Health Insurance Levy (NHIL), a form of indirect tax placed on the same goods and services that are affected by VAT (McIntyre et al. 2008). With the imposition of this levy, VAT has increased from 12.5% to 15%. Third is a 2.5% deduction from the SSNIT contributions of formal sector workers. In Ghana, most formal sector workers and their employers contribute on a monthly basis, 17.5% of the employee's salary to a pension scheme run by the Social Security and National Insurance Trust (SSNIT).

It is from this fund that a monthly deduction equivalent to 2.5% of each employee's salary is made to the NHIS. The deductions are compulsory and hence no SSNIT contributor can opt out of the system. The other sources of funds are: allocations from general tax revenue, donor funds, interest from investments and once-off registration fees paid by all NHIS members (GHS 2004). The informal sector premiums are collected by each DMHIS, the NHI levy is collected by the VAT Secretariat and SSNIT collects the formal sector contributions in the form of payroll deductions.

With regard to pooling, the informal sector's premium goes directly into the accounts of each DMHIS while the other sources of funds are deposited into a National Health Insurance Fund (NHIF) which is meant to play a risk equalisation and cross subsidisation role for the DMHIS. However, what this Fund has done since its inception is only to transfer the contribution of the formal sector members to their respective DMHIS and government funds for the subsidisation of informal sector contributions and indigents (McIntyre et al. 2008). As at June 2010, the scheme had registered almost 70% of the total population of Ghana (NHIA 2010b), but by 2009 only 50% of the Ghanaian population had valid NHI membership ID cards (MOH 2010). By implication, therefore, about half of Ghanaians still have to pay out-of-pocket for health care and hence are not financially protected against health care expenditure.

Services are secured by insured clients via an NHIS member ID card, which is renewed every year. Insured clients are provided with "free" health care from those government, faith-based and private commercial hospitals, health centres and pharmacies that are accredited by the NHIS. Fee-for-service is the mechanism used to pay for drugs and some other services while hospitals are paid via DRGs on the basis of claims made by them to the DMHIS (McIntyre et al. 2008). However, capitation is being considered as an alternative payment mechanism

(NHIA 2010b). The benefit package covers the full cost of inpatient and outpatient services, essential drugs (on the NHI drug list), maternity care (antenatal care (ANC) and delivery), emergency care and eye care (MOH 2004). This covers about 80% to 90% of the total disease burden of Ghana, and what is not covered constitutes the disease burden of the wealthiest class, which are usually very expensive to treat (Agyepong, Adjei 2008).

The steady increase in enrolment into the scheme over the years and its contribution to increasing utilisation of health services have put the scheme on the pathway towards the realisation of universal financial protection (MOH 2009). However, prominent among the challenges associated with the scheme is how to ensure that it becomes completely sustainable, efficient and benefits all Ghanaians equitably. This is because the informal sector of the Ghanaian economy is relatively large and enrolment in the scheme and premiums collected from this sector are currently low and there is no mechanism in place to ensure the sustainability of informal sector enrolment since membership is renewable and premiums paid annually (Gyapong et al. 2007). It has also been demonstrated that the premiums paid by the informal sector are regressive and indigents are difficult to identify for exemption (Akazili 2010) thereby defeating the pro-poor purpose of the scheme. The poor are therefore often left out of the scheme and hence do not benefit equitably from government subsidies for health care. In addition, the administrative cost of collecting these informal sector premiums usually results in very small net revenue returns from premiums which raise issues of efficiency in generating NHIS revenue from the informal sector (MOH 2009).

The sustainability of the scheme and its ability to achieve universal coverage therefore depend largely on the extent to which these premium-related problems within the informal sector are addressed. Addressing these problems could take the form of maintaining the current NHIS system and developing strategies to overcome the challenges or restructuring

the entire NHIS system to fund coverage of informal sector purely from tax revenue (Akazili 2010). It was, therefore, against this background that in an attempt to restructure the NHIS, the current NDC government proposed the introduction of a one-time premium payment for the informal sector. The proposed one-time payment policy can therefore be seen as an attempt at a further development of the NHIS towards universal coverage. Its major focus however is on universal financial protection. This is because although the proposed policy has relevance for the universal access component of universal coverage, a whole range of other interventions such as the provision of health facilities and deployment of staff close to patients are required as well to achieve universal access (WHO 2010).

1. 4. The proposed one-time premium payment (OTPP) policy

It must be noted that, this one-time premium payment policy is a component of a comprehensive health care package promised to Ghanaians in the party's 2008 election Manifesto which reads *"The NDC Government will implement a Universal Health Insurance Scheme which will reflect the universal contribution of all Ghanaian residents to the Scheme. Our universal Health Insurance scheme will guarantee access to free health care in all public health institutions. It will be listed in the health insurance schedule, will not be district-specific and will allow for one time premium payment for registration with the scheme....."* (NDC Manifesto 2008:68). Though the content of the proposed OTPP policy is not yet clear to the general public, speculation among Ghanaians is that it would either take the form of scrapping informal sector contributions so that public health care services would be totally funded from tax revenue, which seems to be in line with the NDC manifesto, or they would have to pay the net present value of all future contributions as a single payment during registration in order to be provided with health care for their entire life.

2. Problem statement

The NDC government has indicated its commitment to the formulation and implementation of the one-time premium payment (OTPP) policy as a way of achieving universal coverage through national health insurance (NHIA 2010b, MOH 2009, NHIA 2010a). It is however not yet clear whether various stakeholders are likely to support or oppose this one-time premium policy. How strong the support or opposition to the policy would be and how that would impact on the feasibility of implementing the policy has not been established. There is therefore a need to investigate the positions, interest, power and potential influence of various stakeholders with regard to this policy so as to contribute to assessing the feasibility of the policy.

Also, the 2009 Independent Health Sector Review reported that *“in terms of perception, the switch to a one-time payment is likely to alter the view of the NHIS as an insurance approach. It would then be seen as a tax-based system for funding curative care (using a third party payment mechanism), with some additional contributions from formal sector workers”* (MOH 2009:62). This also indicates a need to examine stakeholders’ understanding of what a one-time premium payment policy is all about. This is because stakeholders’ support or opposition to the policy are likely to be informed by their understanding of the policy.

Though the policy idea is currently under consideration within the NHIA, their focus is on assessing its long term economic implications (MOH 2009), optimal premium levels and other technicalities. However, over-emphasis on technical content, design and economic implications as justifications for a policy often leads to neglect of the policy process, socio-political context and actor dynamics within which the content would be implemented (Walt, Gilson 1994). This neglect of actor dynamics during the process of policy formulation has

often been cited as responsible for lack of policy implementation and failure of many policies to achieve their designed goals. This is because a sound technical analysis is not enough justification for adopting a policy (Thomas, Gilson 2004) since it is not a guarantee that various stakeholders would support its implementation. The feasibility of a technically well designed and economically sustainable policy could therefore be brought into question through a stakeholder analysis. For instance, a stakeholder analysis conducted on a women and child health programme in India after its design revealed considerable lack of agreement between the funder and government officials and hence the policy was deemed not feasible for implementation and it was therefore recommended that it should be abandoned (Kumar, Chaudhury & Vasudev 1997).

This study therefore seeks to contribute information to assess the feasibility of formulating and implementing the one-time premium payment policy by exploring the views/perceptions of various stakeholders on the policy and assessing their positions, interest, concerns, power and potential influence on the policy through a stakeholder analysis. This will highlight the potential prospects and challenges for the formulation and implementation of the policy and hence its potential impact on achieving the goal of universal coverage.

3. Rationale for the study

Health financing reforms such as introducing a one-time payment NHIS policy are often contentious since they involve decisions about who pays for, and who benefits from health care (Thomas, Gilson 2004). Also, when it comes to issues of social policy of the state, Ghanaians often differ in opinions largely along political lines but sometimes also along technical and professional lines (Agyepong, Adjei 2008). As a political initiative therefore, the one-time premium policy is currently the most socially and politically controversial issue that is central to the restructuring of the NHIS of Ghana. Several political, technical,

administrative and local concerns are therefore bound to be (or are being) raised by various stakeholders with regard to the feasibility of the policy. Conducting a stakeholder analysis at this preparatory stage of the policy is therefore very relevant as it would indicate the views of various stakeholders on the policy that should be taken into account in finalising and implementing the policy and hence help to build into the policy actions that could secure actors' support. On the other hand, it will also indicate the extent of opposition, what the concerns are, the powers of the opponents, and hence will assist policy-makers in assessing whether these concerns can be addressed to promote more support for the policy or whether it would be unfeasible to implement it. The study would also add to the existing literature on feasible options of achieving universal coverage within low-and middle-income countries (LMIC). Other LMICs attempting to introduce universal coverage reforms can therefore make use of the outcome of this study to inform them on which options may be feasible within a developing country context.

4. Research aim and objectives of the study

4.1. Aim

The goal of this study is to undertake a stakeholder analysis of the proposed one-time NHIS premium payment policy in Ghana.

4.2. Objectives

1. To assess the understanding of key stakeholders of the proposed one-time premium payment policy
2. To examine the interest, positions, power and potential influence of key stakeholders in terms of the policy and the reasons for their support or opposition
3. To explore the prospects and challenges for the implementation of a one-time premium policy and for universal financial protection in health care

4. To draw lessons from the study to inform further steps towards the formulation and implementation of the policy and future universal coverage reforms in Ghana and other LMICs

5. A brief literature review for building a conceptual framework for the study

This section contains a brief review of conceptual literature on policy analysis for the purpose of building a conceptual framework for the study. A detailed review is provided in the next part of this dissertation (structured literature review).

Policy analysis is what guides universal coverage reforms toward the realisation of policy goals (Gilson et al. forthcoming). Analysis of policy reforms can be done retrospectively to generate knowledge to aid the understanding of a past reform experience or prospectively to aid the implementation of a proposed policy or to inform future policy reforms (Walt, Gilson 1994). Empirical observation however reveals that proper policy analyses within low-and middle-income settings, especially prospective analyses, are limited (Gilson, Raphaely 2008).

In presenting a framework for policy analysis, Walt & Gilson (1994) argued that the outcome of a policy process towards the realisation of policy goals is determined by the interaction of the policy's content, context, process and actors. In their triangular framework, actors, referred to as stakeholders in this study, are at the centre of this interaction. This study is basically a stakeholder analysis and therefore focuses on understanding the actors' component of the Walt and Gilson (1994) analytical framework. The study deals with actors and their likely reactions to potential policy content and process within the Ghanaian context.

Also, the principles of feasibility, equity, efficiency and sustainability have been identified as useful criteria for assessing the relative merits of health care financing reforms (McIntyre 2007). Here again, a full assessment of these four issues will require an understanding of the

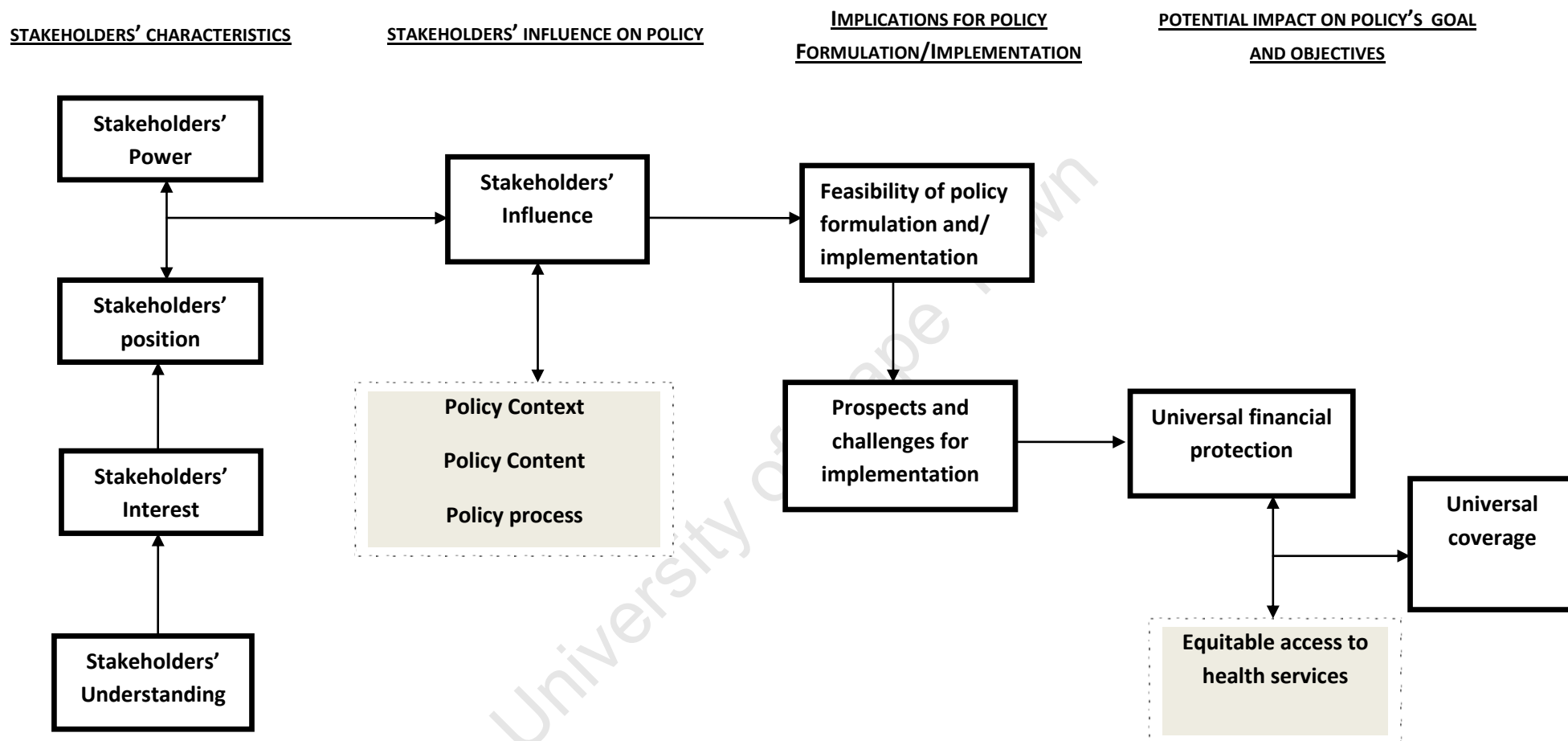
policy context, content, process as well as actor dynamics. The feasibility of a policy, which usually deals with the availability of adequate administrative capacity and the level of stakeholder support or opposition to the implementation of the policy, is what has been reported to have often been neglected in health policy analysis (McIntyre 2007, Walt, Gilson 1994, Thomas, Gilson 2004). A stakeholder analysis contributes to determining the feasibility of policy change through an analysis that focuses on the influences or potential influences of stakeholder characteristics and dynamics on the formulation and/or implementation of the reform (Brugha, Varvasovszky 2000). Stakeholder characteristics used in this study refers to stakeholders' understanding of the policy issue, their interest/concerns, (potential) positions, powers and potential influences over the policy formulation and/or implementation and its overall success. A detailed description of stakeholder characteristics is provided in the structured literature review.

6. Conceptual framework

Drawing from the above review, this study is premised on the conceptual reasoning that various characteristics of stakeholders would determine the kind of influence they will have on the proposed policy and the nature of their influence will have implications for the implementation of the policy and its potential impact on the realisation of the policy's goals and objectives. In relation to stakeholders' characteristics, the study postulates that, stakeholders' understanding of the policy issue will affect their interest in it and their interest will influence their positions on the policy and drawing on the power they possess, they will exert influences on the formulation and/or implementation of the policy (see Figure 1). In an attempt to influence policy, stakeholders usually draw on their interactions with the content, context and process of the policy. These variables, though they are not the main focus of the study, are therefore essential in making judgements about stakeholder interest and power which are at the heart of this study. The nature (positive or negative) and level of influence

that stakeholders are likely to have on the implementation process of the policy will affect the feasibility of implementing it. Establishing the feasibility of implementing the policy would then bring out the prospects and challenges likely to be faced during implementation in relation to achieving its immediate objective of universal financial protection. However, since the ultimate goal of the proposed one-time premium payment policy is to attain universal coverage, the interaction between guaranteed universal financial protection and universal access to needed services is required to facilitate the realisation of universal coverage. But, since other complementary interventions are needed as well for universal access to be realised, the access component of universal coverage will not be considered in detail in this study and has therefore been de-emphasised in the conceptual framework. As a stakeholder analysis therefore, this study mainly focuses on the analysis of the stakeholders' characteristics and their potential influence on the formulation and/or implementation of the policy. However, implications for the feasibility of formulating and/ implementing the policy and its likely impact on universal financial protection will be drawn from the analysis.

Figure1: Conceptual Framework for analysing the potential influence of stakeholders on the one-time NHIS payment policy in Ghana



7. Methodology

7.1. Research setting

The study will be conducted in Ghana: specifically in Accra the national capital, and in the Akuapim South and Kassena-Nankana West districts. Ghana is a former British colony located in sub-Saharan Africa. Ghana gained her independence in 1957. After the overthrow of the first post-colonial civilian government in 1966 through a military coup d'état, the country was faced with a long period of political instability due to frequent changes in government between civilian and military regimes. However, since 1992 Ghana has operated a multiparty democratic system, with elections often keenly contested between the two main political parties (NDC and NPP), and victories sometimes determined through run-offs (second round of voting). The NDC ruled from 1992 to 2000, the NPP from 2001 to 2008 and the NDC returned to power in 2009 through a marginal victory over the NPP in the 2008 presidential run-off election. The NDC has a centre-left ideological leaning while that of the NPP is centre-right (Agyepong, Adjei 2008).

The country has a population of about 24 million (24,223,431) with a sex ratio of 95 males per 100 females and an annual inter-censal population growth rate declining from 2.7% in 2000 to 2.4% in 2010 (GSS 2011). About half of the Ghanaian population is under 15 years and by implication constitutes part of the exempt group of the NHIS (GSS 2005). As at 2000, the urban population across the 10 regions was 44% with the southern sector relatively more urbanised than the north (GSS 2005).

In 2010, Ghana was declared as a lower-middle-income country by the Ghana Statistical Service. Until then (2010), the country had a GDP growth rate of about 6.8% (in 2008) and a fluctuating inflation rate that recently peaked at 20% in 2008 (MOH 2009) though the inflation rate is currently estimated to be at a single digit level. The per capita expenditure on health care since 2006 is estimated to be US\$23, which is below the World Bank's

recommendation of US\$30-40 (MOH 2007). The overall government budgetary allocation to the health sector is about 12% which falls below the Abuja target of 15% for African countries (Jones, Ahadzie & Doh 2008, AU 2006).

There exists a dominant public health sector with private providers constituting about 35% (Results for Development Institute, Adjei 2010). Generally, health facilities and personnel are inadequate in relation to the population that is being served. There are about 1,439 health facilities serving about 24 million residents and the average distance that must be travelled to consult a doctor is about 16km (Salisu, Prinz 2009). The doctor to population ratio is about 1:11,649 and that of nurses to the population is 1:1,172 (MOH 2010). Also, geographic disparities exist in the distribution of providers with rural areas having less access to modern health care facilities. It is reported that about 43% of all doctors are practicing in Greater Accra while the 3 northern regions have only 4% (MOH 2010). Also, over 60% of all formal health care facilities are located in the urban areas though primary health care is much emphasised in Ghana (Akazili 2010).

Malaria and upper respiratory diseases top the disease burden of Ghana with pregnancy related complications also being quite high. Maternal mortality is around 995 per 100,000 live births (GHS 2007) while the infant mortality rate is about 80 per 1,000 live births (GHS 2009). Also, Ghana was ranked 32nd of 194 countries in 2008 in terms of the under 5 mortality rate (UNICEF 2008). Life expectancy in Ghana is below 60 years (56 for males and 58 for females).

The Akuapim South district is located in the eastern region. It is one of the urban districts and is also located in the southern part of Ghana. It is located close to the national capital, Accra, and hence the views from this district may not differ significantly from the views of other urban dwellers especially within the southern part of Ghana. The Akuapim South district has

a district hospital and one of the oldest National Health Insurance DMHIS, which are located in Nsawam, the district capital. The Kassena-Nankana West District (KNWD) is one of the newly established districts in the Upper East Region. The Upper East region is one of the three regions in Northern Ghana. The KNWD is largely rural. Unlike the Akuapim South district, the Kassena-Nankana West district has no district hospital and no national health insurance office of its own. The Kassena-Nankana East DMHIS, located in Navrongo also provides NHIS services to residents of the KNWD, whose capital is Paga. While there are medical doctors in the Akuapim South district hospital, there is no doctor in any of the health facilities in the KNWD. The views that will be gathered from this district may therefore not differ significantly from the views of other rural dwellers in other parts of the country, especially the northern part. The rural/urban logic as applied in the sampling is important because, in Ghana, residents of urban areas generally have a greater ability to pay for insurance than rural areas. Since the OTPP is likely to affect the amount to be paid for insurance, the rural population is likely to respond differently to it from the urban population.

7.2. Study design

This is a qualitative cross-sectional study exploring the opinions of various stakeholders on the proposed one-time NHIS premium payment policy in Ghana. A qualitative design is more appropriate for this study as it offers a better opportunity to explore the opinions, concerns, expectations, possible contradictory behaviours and such intangible issues as power relations and influence of various stakeholders with regard to the proposed policy (Mack et al. 2005). The greater flexibility that a qualitative research design offers would provide an opportunity for probing to gain an in-depth understanding of stakeholder dynamics.

7.3. Population and sampling

The target population for this study is all stakeholders who would have an interest in the proposed one-time premium payment policy in Ghana. All actors within and outside the

health sector, local or international, who it has been established have often shown interest in health financing reforms in Ghana, are targeted in this study. Since the aim is not to achieve statistical representativeness as is often the case with purely quantitative research (Joubert, Ehrlich 2007) but to explore a wide range of views of various stakeholders, the selection criteria would be purposive (Mack et al. 2005, Silverman 2006). With the focus of the study being at the national level, study participants will be included to ensure that the results of the study will reflect the views of both rural and urban dwellers across the northern and southern sections of the country. As a result, although most of the key stakeholders would be selected from the national capital, two districts (one rural and from the north and the other urban and in the south) will be selected for detailed community-level studies through FGDs with beneficiaries and interviews with district-level and frontline implementers of the policy. The table below outlines the proposed stakeholders to be considered in the study.

Table1: Proposed stakeholders to be considered in the study			
Stakeholder category	Organisation/Departments	Specific stakeholder	No.
Policy drivers (authorisers)	Government of Ghana, Ministry of Health	Minister of Health and/or deputy,	2
	National Health Insurance Authority	CEO of NHIA	
Technocrats (national)	Staff of Ministry of Health	Directors and heads of relevant departments or key staff	4
	Staff of the NHIA		
	Staff of Ghana Health service (national) Ministry of Finance	Accountant/financial controller	
Politicians and Legislators	Incumbent political party	Leaders or members of Parliament (MPs)	4
	Opposition Parties	Minority spokesperson on Health and/or party leaders	
	Parliamentary select committee on Health	Chair or member	
Opinion leaders, academics and health researchers		Directors and/or former Directors of Health service, lecturers of public health in Ghana	3
Labour organisations and Unions	Trade Union Congress (TUC), Ghana Medical Association, Ghana Registered Nurses Association, Ghana Registered Midwives Association	Leaders	3
Donors and international collaborators		Country representatives	2
Frontline Implementers	Staff of DMHIS	Managers of DMHIS, Accountants, claims managers	4
	Staff of Ghana Health service	Hospital administrators, public pharmacist, Accountant	3
	Street-level bureaucrats	Nurses, doctors and accredited pharmacists (private)	6
Total			31
Beneficiaries	SSNIT contributors (formal sector) Community level (informal sector)	Teachers: 2 FGDs one in each District(8-12 members each) 2 (1 for men and the other for women) in each District	6 FGDs (48-72 people)

7.4 Recruitment of study participants

All sampled stakeholders for the semi-structured interviews will initially be contacted through a telephone call to inform them about the study and to ask them to arrange time for the interviews. Where contact with participants on phone is not possible, the principal investigator (PI) will make a personal visit to the participants to communicate to them the

purpose of the study and seek permission for the interviews. Each participant will be presented with an introductory letter from the PI's supervisor/UCT. A snowballing technique will also be relied upon to identify the less visible stakeholders for inclusion into the study (Mack et al. 2005). For FGDs, the principal investigator will liaise with community-level gatekeepers through appropriate community entry processes to recruit participants.

7.5. Methods of data collection

In order to be able to appropriately capture a wide range of information from different stakeholders and as a way of methodological triangulation to improve upon the credibility of the study (Mack et al. 2005, Silverman 2006), three data collection techniques will be used in this study. These are: face-to-face semi-structured interviews to be administered to the national-level policy actors and district-level policy implementers outlined in Table 1 above, a review of documents in the public domain such as newspapers and parliamentary debates on the one-time payment policy and focus group discussions (FGDs) to be organised at the community-level for beneficiaries. The semi-structured interviews will enable me to explore the opinions of the individual key stakeholders and that of their organisations on the proposed policy (Giacomini, Cook 2000) although the major limitation of this approach is that the individual stakeholders' opinion may not be a true representation of that of his/her organisation.

Six separate FGDs, three in each selected district, will be organised for informal sector beneficiaries (comprising both registered and non-registered NHI premium contributors) and for the formal sector (SSNIT contributors). For the formal sector, teachers constitute the majority of SSNIT contributors in Ghana and can be organised more easily than those in other formal sector employment and hence one FGD comprising teachers and two community level FGDs, one each for men and women will be organised in each district. The size of each FGD will be between 8-12 people. These FGDs will not only offer the opportunity of

examining the opinions of beneficiaries as a social group but group dynamics within FGDs will stimulate conversation, reactions and hence stakeholders (beneficiaries) will influence each other through their presence and their reactions to the extent that each person can raise issues that s/he would not have revealed under a different setting and condition. However, it is usually more difficult to facilitate processes in focus groups than interviews and hence it will require greater effort and facilitating skills to handle the FGDs (Mack et al. 2005).

Because of the difficulty in contacting all stakeholders for interviews and FGDs, a review of documents in the public domain will help to reveal information on their positions on and concerns about the policy. The interview guides (three different versions), the FGDs guide and a secondary data extraction sheet are attached as an appendix.

7.6. Data collection processes and management

Each semi-structured stakeholder interview is expected to last a maximum of 60 minutes, but the FGDs will be between 60 to 90 minutes each. The data from the interviews and FGDs will be captured by taking down notes and tape recording after obtaining consent. Two research assistants (RAs) will be employed to assist in note taking for the FGDs, but the semi-structured interviews will solely be administered by the principal researcher. With the exception of community-level FGDs, which will be done in the local languages of the two districts, all interviews and FGDs will be done in English since the target population speak English. Space will be provided in the semi-structured interview guides for recording of responses, but tape recording will be done as well where consent is granted. Notes taken by the assistant researchers and the principal researcher (PI) will be compared and compiled immediately after FGDs. Tapes will be played and listened to by the principal researcher and key portions of the tape-recorded interview data will be transcribed. However, data from all FGDs will be transcribed and translated before analysis. A data extraction sheet will be used to extract and record all data from documentary sources. All data collected will be solely

handled and managed by the principal researcher and all used and unused data collection instruments will be securely stored under the care of the principal investigator and they will be destroyed with the tapes after the whole research process. An external hard drive will be purchased to serve the sole purpose of a computer backup device for the data that will be gathered through this study.

7.7. Analysis and presentation of data

Qualitative data analytical tools and techniques will be used for the analysis and presentation of the data. Thematic analysis will be used to analysis interview notes and FGD transcripts while a document analysis will be undertaken for data from documentary sources. A coding frame comprising both deductive (derived from the conceptual framework) and inductive codes will be developed to guide the analysis. Specific stakeholder analysis tools such as force-field analysis, stakeholder matrix, tables, boxes, charts and position maps will be used for the analysis and presentation of stakeholder characteristics. Microsoft excel will be used to develop the spreadsheets for the analysis of stakeholder characteristics. The unit of analysis is that of the group level and hence, the various stakeholder categories as outlined in Table 1 will be considered as the analytical units for this study (Weible 2006).

8. Ensuring quality in the study

Since this stakeholder analysis will elicit the opinions of stakeholders, care must be taken in order not to introduce the biases of the investigator in presenting the opinions of respondents (Mack et al. 2005). To improve upon the credibility of the study therefore, a triangulation of methods and sources of data is proposed. Three different methods, namely: interviews, FGDs and document reviews will be used to collect data in a way that the strengths of one complements for the weakness of the others. Also, the interest, positions and concerns of stakeholders on the policy will be explored from their own opinions as well as the opinions of other stakeholders about them. This provides a means for cross-checking and hence will

improve upon the validity of the data collected. Also, the study seeks to enforce intra-coder reliability through repeated coding by the principal researcher. Multiple means of capturing data, through note-taking by three investigators and tape recording at the same time will also enhance the reliability of the study. Instruments that have already been formulated and used for stakeholder analysis such as the guideline provided by Schmeer (2000) and the checklist used in the SAZA project in South Africa and Zambia (Gilson, Antezana & Bennett 2000, Gilson et al. 2003) were consulted in the design of the interviews and FGD guides for this study.

9. Ethical issues

There will be very minimal risks of participating in this study. However, since the questions are about stakeholders' opinions on the policy, I acknowledge that if the participants have negative opinions of the policy and the study makes known these to the policy drivers or government, it may result into victimisation at the work place (if they are a staff/employee of MOH/NHIA) or it may damage the relationship between the stakeholder organisation and the government. The study however seeks to address this by ensuring that all information gathered from the interviews and FGDs are treated confidentially and the findings will be presented in a way that individuals/organisations will not be identified by names with their opinions unless these views have been made public (such as materials quoted in the media, record of parliamentary debates etc.). There are however, no anticipated major psychological or physical stresses of participating in this study except that participants may have to forgo other activities in order to participate in the study. As an appreciation for participants' time, lunch will be provided during FGDs and the transportation cost incurred to travel to the venues for FGDs will be reimbursed to participants.

As regards benefits from participation, there are no direct material benefits from participating in this study. However, since the results will be made available to the National Health

Insurance Authority to assist in finalizing the policy, the study offers stakeholders a potential platform to make known their opinions on the proposed policy issue. If concerns raised by stakeholders are taken into account by the policy drivers, it will increase the possibility of coming out with a health insurance policy that will be widely accepted by Ghanaians. Hence, participation in this study offers wider benefits to the Ghanaian society.

Participation in this study will be entirely voluntary and participants have the option not to participate or to discontinue their participation without any adverse consequence. All participants will therefore be asked to freely consent to the study. In obtaining informed consent, participants will be given sufficient and relevant information about the study to enable them to choose voluntarily whether to take part or not. Written informed consent forms will be given to participants to sign or thumb print. Two versions of the consent forms will be used: one for interviews and the other for FGDs (see appendix for details). The consent forms for stakeholder interviews will be in English but that for community-level FGDs will be translated into the local language where the participant does not understand English. Informed consent will be obtained by the principal investigator and for community-level FGDs, a translator will assist in obtaining informed consent. Also tape recording will only be done if consent/permission to record is granted.

10. Personnel and Logistics

The data collection is expected to last for a period of two-months, thus from the 20th of November to the 20th of January, 2010. The principal investigator (PI) and two research assistants (RAs) will be responsible for the implementation of this protocol. The principal investigator will be responsible for the recruitment and a brief orientation of the research assistants, for conducting all semi-structured stakeholder interviews as well as facilitating all FGDs for SSNIT contributors and some of the community-level FGDs in the Kassena-Nankana West district. However, one of the research assistants who should be fluent in Twi

(the local language of the Akuapem South district) will facilitate the community-level FGDs in that district and the other who should be fluent in Nankam will also facilitate the community-level FGDs in the Kassena-Nankana West District. The RAs will have a minimum qualification of a bachelor degree and their main task will be to assist in organising, documenting and compiling proceedings from the FGDs. The PI will be the main coordinator of the whole research process and with the support of his supervisor he will be the sole analyst of the data. The main expenditure items in this study include: Salaries and wages of RAs, accommodation and transportation for the three researchers, telephone calls/emailing/faxing, printing and photocopying, tape recorders, purchase of a memory stick, stationery, lunch and reimbursement of transport costs for participants of FGDs and transcription of FGDs. The detailed description of each of the expenditure items and the corresponding cost can be found in the budget attached as an appendix.

11. Write-up and dissemination

The potential users of the results from this study are the NHIA, academic researchers and all the stakeholders who are targeted in this study. The write-up and dissemination of the results from this study will therefore be done in a way that will be suitable for the consumption of all these various potential beneficiaries. A copy of the final dissertation will be presented to the NHIA. A journal manuscript targeted for publication in a peer reviewed journal will be for the consumption of policy makers and the academic community. Lastly, an editorial commentary (opinion piece) will serve to inform health insurance policy makers within Ghana and other LMICs of the study findings.

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Part B: Structured literature review

(Word count= 10,306 excluding references and the 2 tables)

1. Introduction

The aim of this literature review is to provide a conceptual and empirical foundation for the study. It is divided into two main sections. The first section contains a review of conceptual and empirical literature on the concept of universal coverage and particularly universal financial protection which is the objective of the proposed one-time premium payment (OTPP) policy. Particular attention has been paid to specific examples of universal coverage reforms within low- and middle-income countries (LMICs) and the Ghanaian policy context of recent reforms aimed at achieving universal financial protection. The second section presents a review of conceptual literature on stakeholder characteristics and analysis which is the approach used for this study, and empirical literature on actor dynamics with regard to recent health care financing reforms within LMICs.

Both print and electronic resources were accessed through hand searching of journals, books, policy documents and internet searches of Google Scholar, Pubmed, Inter-Science (Wiley), Science Direct (Elsevier), Google, WHO website, Ghana Government website, and the National Health Insurance Authority (NHIA) website. The following key search terms were combined in various different ways: Health (care) financing, universal coverage, universal health care, (universal) financial protection, social health insurance, tax-based health care financing, national health insurance, health (care) financing reforms, health insurance policies/reforms, (health) policy analysis, stakeholder analysis, one-time insurance premium, informal sector, (non) formal sector, low- and middle-income countries (LMICs), developing countries, less developed countries, poor countries, Africa, sub-Saharan Africa, Ghana.

2. Universal coverage

2.1. Background and meaning of the concept

Universal coverage (UC) has been internationally acknowledged as the ultimate goal of sustainable health care financing systems (WHO 2011, WHO 2010, WHO 2005b, WHO 2008a). It was initially proposed and accepted as a goal to be pursued by all member states of the WHO at its 2005 World Health Assembly and was declared one of the four pillars of primary health care in the 2008 World Health Assembly (WHO 2008a). It was the focus of the 2010 World Health Report and the WHO continues to call on all its member states to adopt health care financing systems that lead to universal coverage (WHO 2011, WHO 2010). Moving towards universal coverage is therefore currently the focus of health care financing reforms in most countries (WHO 2010).

Universal coverage means the existence of a health system that provides all residents with equitable access to suitable and affordable health care according to the health care needs of the residents (Carrin, James 2004). It has two different but interlinked components: universal financial protection and equitable access to needed health services for all residents (WHO 2010, Kuzin 2007, McIntyre, Kutzin 2010). The equitable access component implies that all residents of a country should be able to obtain access to both personal and non-personal health services that are needed by them (WHO 2008a, Evans 2007) and the service package must be adequate to cover their preventive, curative, rehabilitative and health promotional needs (WHO 2010, Carrin, James 2004). This review focuses predominantly on financing mechanisms for achieving universal financial protection and hence universal coverage, with specific emphasis on the context of low- and middle-income countries.

2. 2. The concept of universal financial protection

Universal financial protection refers to the shielding of all individuals or households against significant income losses or impoverishment as a result of payment for health care (Arhin-

Tenkorang 2000, Kutzin 2000). It implies that citizens should not be required to make (substantial) out-of-pocket payments for health care at the point of service provision that could have catastrophic consequences (WHO 2010). Catastrophic consequences of health care expenditure refers to the situation whereby a household spends a certain proportion of its income on out-of-pocket expenditure on health care which eventually throws such household into (or deeper into) poverty (Arhin-Tenkorang 2000, Glaser 1991, Xu 2003, McIntyre 2006). Household health care expenditure exceeding either 10% of total household income or 40% to 50% of household income remaining after meeting basic consumption needs such as food and shelter is considered catastrophic (Xu et al. 2006, Ranson 2002, Russell 2005). The argument for universal financial protection is therefore premised on the basis that uncertainty in the timing and cost of illness often leads households into catastrophic health care expenditure (Evans 2007, Arhin-Tenkorang 2000). Hence, prepayment systems funded from taxes and insurance contributions have been advocated for the realisation of universal financial protection (WHO 2010, WHO 2005b).

2.3. Basic requirements for universal financial protection

The move towards universal financial protection requires that health care expenditure is largely or wholly financed through a progressive prepayment mechanism within an effective system of integrated risk and resource pooling (WHO 2010, WHO 2005b, McIntyre, Kutzin 2010, Evans 2007). Prepayment systems *“are based on payments made in advance of an illness, pooled in some way and used to fund health services for everyone who is covered”* (WHO 2010:12). As a requirement for universal financial protection, the rich (the relatively better off) should pay a higher percentage of their income to the prepaid fund than the poor (relatively worse-off). There should therefore be no caps such as upper limits on the amounts people contribute to the pooled fund (McIntyre, Kutzin 2010, McIntyre, Gilson & Mutiyambizi 2005). The prepayment arrangement must also be designed in such a way that it

is not possible for some citizens (especially the rich) to opt out of the system (McIntyre, Kutzin 2010). The system is built on the principle of cross- subsidisation whereby the rich pay part of the health care costs of the poor (income cross-subsidy) and similarly, the healthy for the sick (risk cross-subsidy), the young for the old and even the urban dwellers cross-subsidise rural dwellers (WHO 2010, McIntyre, Kutzin 2010). It is also recommended that the poor who cannot make direct contributions are covered through public funds (taxes) for universal financial protection to be realised (WHO 2010). Increased public spending on health care is therefore crucial for universal coverage (WHO 2011).

To improve the ability of citizens to contribute effectively to publicly pooled funds, and also for governments to be able to raise additional revenue to increase public spending, it is often stated that there must exist strong economic growth, large formal sector employment and a large fiscal space among other factors (Evans 2007, McIntyre 2007, Carrin, James 2005). It is, however, argued that these conditions are not favourable within the context of low-and middle-income countries. Hence, governments of LMICs have a limited ability to mobilize additional revenue from domestic sources in order to increase the proportion of public expenditure on health care (McIntyre 2007, Tangcharoensathien et al. 2011).

Some scholars have however, indicated that additional public revenue can still be mobilised by improving upon the administration and efficiency of tax collection, reducing allowable deductions on tax returns, ensuring that an earmarked percentage of indirect tax (VAT) is allocated for health care while cutting down on unnecessary expensive public expenditure like foreign travels by government officials and excessive military activities (McIntyre 2007, McIntyre, Gilson & Mutyambizi 2005). The 2010 World Health Report also recommends increased government priority to the health sector in terms of budgetary allocations and innovative strategies such as increasing taxes on foreign travels and foreign exchange

transactions, Diaspora bonds, solidarity levies on products such as mobile phones as well as taxes on harmful products like alcohol, tobacco and sugary drinks as other ways of raising additional revenue within LMICs. Notwithstanding the above, the WHO (2010) again called upon the international community to support the efforts of poor countries to achieve universal coverage.

Also, the existence of strong political commitment, government stewardship, social solidarity and a high level of population trust in its governance system are other essential ingredients for the transition to universal coverage (WHO 2010, Evans 2007, Yang, Holst 2007, Hsiao 2007). Some degree of compulsion through the enforcement of legislative instruments is also necessary for universal financial protection (Carrin, James 2004).

However, it must be noted that universal financial protection is not the end goal of health systems financing but a means to achieving the ultimate goal of universal coverage. As citizens contribute as much as they can to the pooled fund, they should therefore also be given the opportunity to benefit from health care as much as they need. Equity in the distribution of health service infrastructure and health personnel is therefore recommended as a pre-requisite for universal coverage as it offers the insured population (those with financial protection), irrespective of their location and socio-economic status, equitable access to good quality health care (WHO 2010, WHO 2005b).

2.4. Prepayment systems for achieving universal financial protection

2.4.1. Introduction

Prepayment health care financing systems can be viewed in different ways: contributory health insurance vs. tax-funded systems, mandatory vs. voluntary prepayment systems and mixed prepayment systems. These different ways of looking at prepayment systems and their advantages and disadvantages are discussed below.

2.4.2. Contributory health insurance vs. tax-funded systems

Based on the predominant sources of funding, prepayment health care financing systems can be classified into taxed-based financing (TBF) and contributory health insurance (CHI) systems (Evans 2007, Savedoff 2004).

In a tax-funded system, health care is funded from general tax revenue, earmarked taxes and other forms of government revenue (McIntyre, Kutzin 2010, Wagstaff 2010). General tax revenue comes from personal income taxes, company taxes, general sales tax (GST) or value added tax (VAT), custom and excise tax and fuel levies, among others (McIntyre 2007, Savedoff 2004). Earmarked or dedicated taxes offer more opportunities for sustainability in health sector revenue than general taxes. This is because while earmarked taxes are specifically collected and allocated to the health sector (Maxwell 1988), health has to compete with other sectors of the economy for allocations from general tax revenue (McIntyre 2007). Earmarked taxes for funding health care are however, limited in existence. Within LMICs, earmarked taxes exist in few countries. These include Zimbabwe for HIV/AIDS treatment; Ghana, which has dedicated an additional 2.5% VAT for health care; and Latvia, which implemented a dedicated tax for health care between 1998 and 2003 (McIntyre 2007, Tragakes et al. 2008). However, in the case of Ghana and Latvia, these dedicated taxes are/were used to support insurance systems. In general, the main source of revenue for a tax-funded system is general tax revenue (McIntyre 2007, Savedoff 2004).

Contributory health insurance systems comprise: social health insurance (SHI), community-based health insurance (CBHI), private health insurance (PHI) and national health insurance (NHI) systems. The concept social health insurance has been defined and used differently by various authors. Some writers limit its definition and application to the type of health insurance that covers only specific groups who contribute to the SHI fund, such as formal

sector workers (Wagstaff 2009, Carrin 2003). Others have defined and used it in the broader sense to cover all forms of non-profit oriented health insurance systems that target the poor or the broader society (Hsiao 2007). It is in the light of this that the literature seems to also present a limited distinction between SHI and National Health Insurance (NHI). This study considers SHI as the kind of insurance that targets the formal sector, where contributions are income-rated and payroll deducted, and contributors and their dependants are entitled to a minimum standardised benefits package (Hsiao 2007). In an SHI system, the premium is usually charged as a percentage of an employee's salary and it is paid by the employee and/or the employer (Hsiao 2007, Hoare, Mills 1986, Ron, Abel-Smith & Tamburi 1990).

CBHIS are usually not-for-profit insurance schemes. They target the informal sector, contributions to such systems are community-rated and often charged at a flat rate, and some do provide premium exemptions for the very poor (Carrin 2003, Arhinful 2003, Eklund, Stavem 1996).

In this study, NHI is seen to be broader than SHI and CBHIS. An NHI system refers to an insurance system that targets the entire population seeking to cover both the formal and informal sectors as well as the poor who cannot afford to make a contribution (McIntyre, Gilson & Mutyambizi 2005). With an NHI, part of the premiums, especially that for the poor, is paid from tax revenue (McIntyre, Gilson & Mutyambizi 2005). Hence, some scholars have referred to an NHI system as that of a universal health system (McIntyre, Gilson & Mutyambizi 2005, McIntyre 2010).

Private health insurance systems, on the other hand, are non-state controlled schemes that either operate on a for-profit or not-for-profit basis (McIntyre, Gilson & Mutyambizi 2005,

Ataguba, Akazili 2010). For this study, the concept of private health insurance is limited to only private for-profit health insurance systems.

There is a debate in the literature as regards which system, tax-funded or contributory health insurance, is more suitable for moving towards universal coverage. It is argued that, since contributory health insurance systems involve regular direct contributions to the pooled fund, they guarantee security and sustainability in funding health care more than tax-funded systems where the allocation of tax revenue to the health sector depends on the economic situation at a particular point in time and the level of political commitment to the health sector (Hsiao 2007). Moreover, since revenues from insurance premiums are directly used for health care, it is argued that residents are usually more likely to accept to pay insurance premiums than higher taxes (McIntyre 2007, Wagstaff 2010). It is also believed that, contributory health insurance make people more responsible for their own health care than tax-funded systems, where contributions are usually indirect and in most cases people feel the services are offered free of charge (Svedoff 2004).

On the other hand, in countries where contributory insurance systems are introduced, governments tend to view them as substitutes for budgetary allocations to the health sector and hence sometimes allocate less of the budget for health care (Wagstaff 2010, Langenbrunner, Sheiman & Kehler 2008). Also, it is usually difficult and administratively expensive to enforce contributory health insurance within the informal sector where most workers are self-employed (Wagstaff 2010, Svedoff 2004). Also, unlike tax-funded systems where resources and risks are pooled from the whole population into a single integrated pool that allows effective cross-subsidisation, pooling and cross subsidisation in contributory health insurance systems is limited within the contributing groups and often fragmented if

there is no effective risk equalisation system for their integration (Wagstaff 2010, McIntyre et al. 2008).

In addition, while insurance contributions are usually at best proportional (if payroll deducted) and at worse regressive (if extended to the informal sector), tax-funded systems are relatively progressive since direct taxes are usually progressively structured and even within poor countries where most commodities consumed by the poor are exempted from indirect taxes, even indirect taxes like VAT have also been reported to be progressive (McIntyre, Kutzin 2010, Kutzin 2000, Kutzin et al. 2009, Kutzin 2007).

Contributory health insurance is not therefore likely to succeed in extending coverage to the informal sector if solely relied upon. Tax funding looks appealing for universal coverage, especially in terms of extending coverage to the informal sector, but prevailing economic and political conditions can also limit its sustainability.

2.4.3. Mandatory vs. voluntary prepayment systems

On the basis of the degree of legal compulsion that exists with regard to contribution to the prepaid fund, the options for universal coverage are sometimes classified into mandatory and voluntary prepayment systems (McIntyre, Kutzin 2010). Mandatory systems are usually established by legislative instruments. They include taxation and compulsory health insurance systems such as SHI and mandatory NHI while the voluntary ones are CBHI and private health insurance systems. The key weaknesses of voluntary prepayment systems are that: they make provisions for opting out; they are associated with adverse selection; they lead to fragmentation in pooling; they are limited in population coverage and hence are associated with inequities in financial protection (Mills 2007). Cross-subsidisation in voluntary systems is usually not effective, since the rich tend to self-select into private insurance schemes while the poor are usually left in CBHIS. As a result, the rich only cross-

subsidise the health care costs of their fellow rich and similarly, the poor cross-subsidise their poor counterparts (McIntyre 2007). A higher degree of political commitment is required for the implementation and sustainability of mandatory systems than voluntary systems (McIntyre, Kutzin 2010). For these reasons, it is not likely that voluntary prepaid systems can achieve universal coverage if totally relied on.

2.4.4. Mixed prepayment systems

It is argued that the conventional classifications of prepayment systems discussed above is inadequate in describing health systems, since such classifications limit the spectrum of universal coverage reform options that are available to countries (Kutzin 2000). Also, such classifications tend to ignore the fact that neither a single tax-funded system nor a single contributory insurance system can be relied upon as a one-size-fits-all model for universal coverage (Kutzin 2000). Each of these options has its relative merits and demerits specifically in relation to how it is designed and implemented within the political, socio-economic and institutional context of the country under consideration (WHO 2010, McIntyre, Kutzin 2010, Wagstaff 2010, Mills 2007, Agyepong, Orem & Hercot 2011). Moreover, there is practically no country that operates a health care financing system that is purely tax-funded or exclusively based on contributory insurance (WHO 2010, Wagstaff 2009).

It is against the above background that some scholars advocate for an approach to health care financing that pools resources from a wide range of financing sources in a way that is contextually appropriate irrespective of the name such as system bears (Kutzin 2000, McIntyre 2010, Kutzin 2007, Mathauer 2009, Gupta 2007). A framework for analysing health care financing systems based on this mixed pooling view has been provided by Kutzin (2001). This framework puts emphasis on an integrated system of revenue mobilisation,

pooling of funds and risks, purchasing and provision of health care services as essentials in the (re-)organisation of health care financing systems (Kutzin 2001).

Another framework for universal coverage which puts emphasis on pooling from different sources is provided by Mathauer (2009). In her framework, three essential elements for universal financial protection and hence universal coverage have been outlined. These are: the proportion of the population that is covered by prepayment financing systems which is referred to as the breadth of coverage; the range of health services covered by this public funding which is the depth of coverage; and the proportion of health care cost that is covered by prepayment funds which is referred to as the height of coverage (McIntyre 2010, Mathauer 2009). Mathauer (2009) and other writers who adopted or referred to this framework in their work (WHO 2010, McIntyre 2010, Nguyen 2011) argue that a country must examine its current coverage levels in relation to the potential maximum attainable levels so as to identify the constraints on extension of coverage. To them, the move towards universal coverage entails efforts at extending the breadth, depth and height of coverage towards the desirable maximum levels. The desirable target for universal coverage is 100% coverage in breadth, depth and height but no country has ever achieved that (WHO 2010). It is therefore very difficult, if not impossible, to achieve very high population coverage with very comprehensive coverage in services and cost. There is always a trade-off that should be made within the three areas of coverage (WHO 2010, Mathauer 2009).

2.4.5. Conclusion

This section has illustrated that there is no single health care financing system that is a one-size-fits-all model for universal coverage. Contributory health insurance cannot exclusively be relied on to provide universal coverage because such systems are difficult to implement within the informal sector. Tax-funded systems are universal in contribution, relatively

progressive and less expensive to run than contributory insurance systems. However, contextual and political conditions can also limit their sustainability. Mandatory prepayment systems are a necessary condition for universal coverage. Mixed prepayment systems which involve pooling of funds and risk hold greater prospects for universal coverage and hence are currently at the core of the universal coverage debate.

2.5. The concept of health insurance

There is often limited distinction between insurance as an objective of health care financing and the instruments that are used to realise this goal (Kutzin 2007). It is argued that the direct policy objective of every prepayment system is to achieve financial protection (Kutzin 2007). This is reflected in the definition of health insurance according to Gupta (2007) as what “*can help defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households*” (Gupta 2007:111). Any health care financing system which achieves financial protection can therefore be referred to as an insurance system no matter how it is funded (Kutzin 2007, Gupta 2007). Kutzin (2007) argues that the existence of an insurance scheme is only one instrument for achieving the insurance objective but it does not necessarily guarantee insurance in the sense of financial protection. Also, it is possible to have insurance in the absence of an insurance scheme. According to him, fully tax-funded systems or health care subsidies that protect residents from bearing the full cost of health care are also ways of achieving the insurance objective.

Confusion in the use of the term insurance is quite common. For example, McIntyre (2010) reported that the use of the term national health insurance (NHI) as used in the intended reforms of the South African health care financing system has created confusion given that it is intended to be (largely) tax-funded. This perhaps is because many understand the concept of insurance to imply a direct contributory insurance system and hence it is difficult for them

to appreciate how a tax-funded system will be considered as an insurance system. It is therefore worth noting that stakeholders can reject reforms that have the potential of insuring the population just on the grounds that they bear “vocabulary” that do not conform with their understanding of the concept of insurance (McIntyre 2010).

2. 6. Empirical evidence on approaches to universal financial protection

2.6.1. Introduction

This section examines progress in implementing prepayment systems, in covering formal sector workers, the poor and informal sector workers. Particular emphasis is given to specific empirical examples from LMICs.

2.6.2. Countries on the path to universal coverage

Globally, a few countries such as Germany, Belgium, Austria, Japan, Korea, Thailand and Malaysia are often cited as countries that have attained universal coverage (WHO 2010, Carrin, James 2004, Evans 2007, Tangcharoensathien et al. 2011, Jongudomsuk 2007). Most of these are high-income countries, but some low- and middle-income countries that were acknowledged by WHO (2010) as popular examples of countries on the pathway to universal coverage are: “Chile, Colombia, Cuba, Rwanda, Sri Lanka and Thailand” (WHO 2010:7). Countries such as “Brazil, Costa Rica, Ghana, Kyrgyzstan, Mongolia, the Republic of Moldova, Gabon, the Lao People’s Democratic Republic, Mali, the Philippines, Tunisia and Viet Nam” (WHO 2010:7) have also been reported to have made significant progress in implementing prepayment systems.

2.6.3. Covering the formal sector via contributory health insurance

Empirical evidence suggests that contributory health insurance, specifically SHI, can be successful in guaranteeing financial protection for the formal sector (WHO 2005a). Apart from Thailand, which has a relatively large informal sector the economies of most of the other countries that have attained universal coverage are largely formalised. This made it

relatively easy for them to enforce contributory health insurance mechanisms, specifically SHI. However, even with economies that have relatively large formal sectors, it can still take a long time to achieve universal financial protection through contributory health insurance (Bärnighausen, Sauerborn 2002). For instance, it took Germany (the first) 127 years, Belgium 118 years, Austria about 77 years, Japan 36 years and the Republic of Korea (most recent) 26 years to achieve universal financial protection through compulsory contributory health insurance (McIntyre 2007, Carrin, James 2005).

2.6.4 Covering the poor through exemption packages

It has been documented that targeted exemption packages financed out of tax revenue was mainly relied upon by some Southeast-Asian countries to provide financial protection for the poor and vulnerable (Tangcharoensathien et al. 2011, Bodart, Jowett 2007, Tangcharoensathien et al. 2009). These programmes however, were not effectively implemented. The following are specific examples as reported by the above authors. Lao introduced a user fee exemption package for the poor in 1995 but it failed partly because village leaders identified the poor on an ad hoc basis. Indonesia introduced a targeted tax-based financing scheme for the poor but financial limitations affected its success. The Philippines initiated a sponsored targeted programme for the poor who were supposed to be identified by local government authorities but its success was largely dependant upon political will and availability of economic resources. Thailand (1975-2002) introduced exemption for the poor under which the poor were supposed to be identified by health workers, and later under a means test, but nepotism affected its success. The problem has been that the target beneficiaries of these programmes were very difficult to identify. Colombia tried to depend on survey data on incomes to identify the poor, while Thailand and the Philippines, depended largely on local authorities to identify the poor, but in all cases the implementation of exemption packages have been ineffective (Hsiao 2007). Ineffectiveness

in the implementation of targeted exemptions for the poor has also been reported in Ghana and other LMICs (Hsiao 2007, Garshong et al. 2001, Nyonator, Kutzin 1999).

2.6.5 Covering informal sector workers through contributory health insurance

In Southeast-Asia, the Philippines, Vietnam and Korea have implemented contributory health insurance schemes for the informal sector with premiums collected from taxi drivers, meat sellers, street vendors and other non-payroll income earning occupational groups (Yang, Holst 2007, Tangcharoensathein et al. 2011, Anderson 1989). African countries such as Rwanda, Uganda and Senegal have also relied largely on CBHIs to extend coverage to the informal sectors of their economies (Samson 2009, Jütting 2004). Evidence from these experiences has shown that not only has it often been very difficult to enforce premium contributions in the informal sector, but in most cases subsidisation from tax revenue was still required for the survival of the schemes (Tangcharoensathein et al. 2011, Jütting 2004). A recent review therefore noted that without adequate supplementary government funding and political stewardship, contributory health insurance tends to have negative implications for the equity and efficiency of financing health care for the informal sector (Joint NGO 2008).

For instance, the Philippines and Colombia in 1995 and 1993 respectively, introduced contributory health insurance systems for universal coverage (Hsiao 2007). These countries put in place innovative measures in order to get the poor and informal sector workers to enrol into the schemes but none was able to achieve its universal coverage targets because most of the poor and the informal sector workers still could not be covered. Colombia for instance heavily subsidised the premiums for the poor and the informal sector while reducing their benefit package but this trade-off still did not yield the needed results for universal coverage. The Philippines has recently tried to identify informal sector workers by the groups, associations, co-operatives or microfinance organisations they belong to and hence use such

groups as a means of enrolling and collecting premiums from them (Hsiao 2007, Jowett, Hsiao 2007).

Rwanda is one of the low-income countries whose efforts at achieving universal coverage have been acknowledged internationally. Rwanda has been reported to have achieved population coverage of over 80%, though the Rwanda government puts the figure at about 91% (WHO 2010, WHO 2008b). Coverage under the Rwandan system is limited in terms of depth (services) and height (cost). Rwanda operates three separate health insurance schemes: one for formal sector government and private (though voluntary) employees, another for the military and the other scheme for the rest of the population who are mostly found in the rural informal sector. The Rwandan system is however, not an exclusively contributory insurance system as only half of the funds are from premiums collected from members of the schemes and the other half comes from government revenue through taxes and donor funds (WHO 2010). Apart from challenges in relation to how to expand the width and height of coverage, the other major obstacles in the Rwandan system are how to make the premiums affordable to the poor and those in the informal sector as well as overcome fragmentation in pooling due to the absence of a national legal framework for the integration of the three different schemes (WHO 2010, WHO 2008b).

2.6.6. Universal coverage through tax funding in Thailand

The experience of Thailand can be described as a major success story within the LMIC setting. Having unsuccessfully tried to completely cover the entire informal sector through contributory health insurance schemes, Thailand adopted a general tax-funded system after its 2001 general election in order to extend the breadth of coverage to the 30% of the population that was still uncovered (Limwattananon, Tangcharoensathien & Prakongsai 2005). This enabled Thailand to cover about 98% of its population (Tangcharoensathien et al. 2011). All

those who were not already covered under any of the existing SHI schemes were identified and government paid for their coverage from tax revenue (Tangcharoensathien et al. 2007). The funds from all the existing SHI schemes were pooled together into a national pool and providers are contracted on a capitation basis while beneficiaries are issued with universal coverage membership ID cards that they use to register with their providers (Hanvoravongchai, Hsiao 2007).

It was the election that offered the window of opportunity for Thailand to do away with a contributory health insurance system in favour of a tax-based system for the informal sector (Tangcharoensathien et al. 2011, Hanvoravongchai, Hsiao 2007). This is because it was one of the main campaign promises of the Prime Minister during the election campaign (Hsiao 2007). It is also reported that at the time, it had already been established that such a system was feasible (Tangcharoensathien et al. 2011). However, its long term financial sustainability is still not clear (WHO 2010, Somkotra, Lagarde 2009). This is because the benefit package is comprehensive and there are no co-payments or deductibles, though their capitation system is reported to be very effective (WHO 2010).

2.7. The Ghanaian approach to universal financial protection

The issue of universal financial protection is not new in the Ghanaian history of health care financing. A detailed description of the historical context of health care financing in Ghana since the colonial period is provided in 'Part A' of this dissertation (study protocol) and hence it has only been summarised in Table 1 below. Only the key issues of Ghana's most recent attempt at universal coverage, how it relates to the experience of universal coverage reforms in other LMICs, and the key findings of relevant recent studies on this Ghanaian effort are highlighted in this section.

Table1. Health care financing reforms in Ghana and implication for universal coverage (UC)					
Year/ Period	Financing system	Rationale/objective	characteristics	Implications for universal coverage (UC)	
				Prospects	challenges
1957	<i>Tax -funded</i>	<ul style="list-style-type: none"> •driven by good economic performance, strong natural resources and exports base at the time •Driven by socialist ideology of the then ruling party 	<ul style="list-style-type: none"> •Free health care at all public facilities •Funded from general government revenues (taxes and donor funds) • Out-of-pocket payments (OOP) for private health care services. 	<ul style="list-style-type: none"> • provided protection against OOP payment at public facilities • comprehensive coverage of population, costs and services 	<ul style="list-style-type: none"> •unsustainable due to decline in economic performance and a change in government • insufficient budgetary allocations to health sector due to absence of earmarked tax
1970s	<i>Nominal fee payments</i>	<ul style="list-style-type: none"> • To limit “unnecessary” use • To recover part of recurrent cost • Conditionality of IMF and World bank 	<ul style="list-style-type: none"> • Public health care was funded from general tax revenues and minimal user fees in the form of co-payments • OOP payments for services at private facilities 	<i>offered some financial protection in terms of breadth and depth of coverage</i>	<ul style="list-style-type: none"> •Limited financial protection in terms of height of coverage (cost) •Declining utilisation of public health care services
1985	<i>“Cash-and-carry “ (out-of-pocket payments)</i>	<ul style="list-style-type: none"> • To recover full cost for drugs • A conditionality for IMF and World bank loans under the Structural Adjustment Programme (SAP) 	<ul style="list-style-type: none"> • Substantial user fees at public facilities at the point of service • Reduced fees for children and primary care • OOP payments for services at private facilities 	<i>User fee exemptions for pregnant women, the aged and the vulnerable</i>	<ul style="list-style-type: none"> • Exemptions were poorly implemented • Poor financial protection at the time • Decline in utilisation of public health services
1990s - Early 2000s	<i>Community-based health insurance</i>	<ul style="list-style-type: none"> •To provide protection against OOP cost •encouraged and supported by NGOs and later the Ministry of Health 	<ul style="list-style-type: none"> •Funded from community contributions with support from some donors •Covered mainly the informal sector 	<ul style="list-style-type: none"> •Financial protection for a few •Provided experimental basis for building solidarity for UC 	<ul style="list-style-type: none"> • Limited in population coverage (only 1%) • Limited and fragmented pools, hence inequities in financial protection
2003/4	<i>Mandatory National Health Insurance (NHIS)</i>	<ul style="list-style-type: none"> • To abolish cash- and-carry system • An election promise by then ruling party 	<ul style="list-style-type: none"> • Mandated by an Act of parliament •Funded from : <ul style="list-style-type: none"> - 2.5% (VAT) National Health insurance (NHI) levy - 2.5% payroll deductions from formal sector workers’ SSNIT^a pension fund - Premiums from the informal sector and those formal sector workers not under SSNIT - Proceeds from NHIA^b investments - Budget allocations and donor funds 	<ul style="list-style-type: none"> •Targets both formal and informal sectors •Made NHI membership compulsory • Implies the existence of political will for UC •Covered over 60% of the Ghanaian population (NHIA, 2010b) 	<ul style="list-style-type: none"> •Still effectively voluntary for informal sector workers •District-based with fragmentation •Relatively low population coverage of the informal sector •Regressive informal sector premiums •Low impact on out-of-pocket payment and hence the persistence of the cash-and-carry system
2008	<i>One-time NHIS premium payment(OTPP) proposal</i>	<ul style="list-style-type: none"> •Based on a recognition of low NHIS enrolments from the informal sector as a threat to UC •An election promise 	<ul style="list-style-type: none"> •Not clear but most likely targeting only the informal sector (Agyepong et al, 2011) •No policy document in the public domain • Issue to be considered by this study 	A key focus of this study	A key focus of this study

Source: (Ramachandra & Hsiao, 2007; MOH, 2004; Agyepong et al, 2011) Note: SSNIT = Social Security and National Insurance Trust. a. Formal sector employees contribute 5 percent of their incomes to the SSNIT and their employers pay 12.5 percent which sums up to 17.5% of employee’s salary per month. NHIA=National Health Insurance Authority. b= NHIA is the managing and coordinating body of the NHIS

As shown in Table 1, the most recent attempt at universal financial protection in Ghana came in 2004, when a mandatory NHI scheme became operational (MOH 2004). The Ghanaian approach has been applauded in the literature as one of the most innovative strategies in Africa (McIntyre 2007, Samson 2009, MOH 2009). This is because it is in contrast with what Kutzin (2007) referred to as the myth that health insurance must first be introduced for the formal sector and then later extended to the informal sector; Ghana's reform aimed from the outset to cover the entire population. The Ghanaian NHIS was developed out of Ghana's experience with CBHIS that operated in the informal sector for many years before the introduction of the NHIS (McIntyre 2007).

As illustrated in Table 1, insurance premiums are collected mainly from the informal sector. These informal sector premiums are supposed to be structured according to ability-to-pay as shown in Table 2 below.

Table 2: Criteria for charging differentiated premiums

Social group	Description	Minimum contribution
Core poor (A)	<i>Adults who are unemployed and do not receive any identifiable and constant support from elsewhere for survival.</i>	<i>Free</i>
Very poor (B)	<i>Adults, who are unemployed, but receive identifiable and consistent financial support from sources of low income.</i>	<i>GH¢7.20 (US\$4.8)</i>
Poor (C)	<i>Adults, who are employed, but receive low returns for their efforts and are unable to meet their basic needs.</i>	<i>GH¢7.20 (US\$4.8)</i>
Middle income (D)	<i>Adults, who are employed and able to meet their basic needs</i>	<i>GH¢18.00 (US\$ 12)</i>
Rich (E)	<i>Adults, who are able to meet their basic needs and some of their wants</i>	<i>GH¢48.00 (US\$32)</i>
Very rich(F)	<i>Adults, who are able to meet their needs and most of their wants</i>	<i>GH¢48.00 (US\$32)</i>

Source: (NHIA 2009)

However, as the NHIS currently operates, many of the district schemes (DMHIS) charge a flat rate premium because of the difficulty in assessing households' income levels for enforcing differentiated premiums (McIntyre et al, 2008, Jehu-Appiah et al. 2011). This makes the informal sector premiums very regressive (Akazili 2010). The burden of direct payments to the NHIS is solely on informal sector households as companies currently do not contribute to the NHIS funding and most formal sector workers (SSNIT contributors) are also exempted from paying the DMHIS premium (Agyepong, Adjei 2008, Asenso-Boadi, Agbeibor 2010).

It is also important to note that, if what is contained in the NHIS ACT, Act 650 (2-3), is anything to go by, formal sector workers who are under the SSNIT pension scheme may not in reality be contributing to the NHIS. This is because the government has assured them that, their future pension payment will be based on the full 17.5% of their contributions to the SSNIT fund and not the remaining 15% after the 2.5% deductions are made to the NHIS on their behalf (Agyepong, Adjei 2008, Wahab 2008). In effect, the SSNIT component is a form of loan to government from SSNIT to finance the NHIS rather than a health insurance premium that is collected from members of SSNIT. However, there is currently no data in the public domain as to whether or not government is repaying SSNIT.

Similar to the challenges faced by other LMICs in enforcing premiums payments in the informal sector (Tangcharoensathien et al. 2011, Jütting 2004), the process of collecting these informal sector premiums in Ghana has been described as very cumbersome, expensive and prone to fraud on the part of premium collectors (Akazili 2010), yet the revenue that is generated from these premiums constitute only a small proportion of the income base of the NHIS (Results for Development Institute, Adjei 2010). It is the 2.5% National Health

Insurance Levy, charged on all VAT-able goods (McIntyre et al. 2008), that contributes almost 70% of the total funding to the NHIS (Results for Development Institute, Adjei 2010).

As an indication of progress towards universal financial protection, total prepayment funding as a proportion of domestic health care expenditure in Ghana was recently estimated to be about 53% while the remaining 47% still comes from out-of-pocket expenditure (Akazili 2010). For the prepayment component, general tax revenue constitutes about 47% while insurance contributions constitute only 5% (Akazili 2010). This implies that even with the introduction of the NHIS, prepayment funding for health care is still largely from tax revenue. A recent study also found that out-of-pocket expenditure as a proportion of private expenditure between 2000 and 2007 only reduced by 0.3% (Soors 2010). Brugiavini & Pace (2010) therefore reported that the Ghanaian NHIS has not had a significant effect on out-of-pocket expenditure yet.

As regards population coverage under the NHIS, there have been considerable debates and inconsistencies in the literature. However, many reports, studies and conference presentations have reported population coverage of between 50% and 70% (Akazili 2010, Asenso-Boadi, Agbeibor 2010, NHIA 2010b, MOH 2010, Durairaj, D'Almeida & Kirigia 2010). A recent publication by Oxfam in collaboration with some local Ghanaian NGOs, which has been widely challenged, indicates that the population coverage could be below 18% (Oxfam et al. 2011). Other low estimates were those by Nguyen (2011), who reported population coverage of about 35% in 2007 and Boateng (2008) who reported 42% population coverage for the same year. What is, however, clear in the literature is that Ghana has not yet attained universal population coverage. It is also indisputable that the majority of those who are not yet covered are the poor and informal sector workers whose membership is dependant upon the payment of the premium (Akazili 2010, Asante, Aikins 2008). However, because SSNIT

contributors are also required to go to a scheme's office to register, pay a registration fee and renew their membership on an annual basis, quite a number of them are also not covered under the NHIS.

However, while some are concerned about the long-term sustainability of the scheme and hence are calling for a reduction in the benefit package and the introduction of co-payments (Witter, Garshong 2009), others are suggesting that the surest way of attaining universal coverage is to adopt the Thailand approach of fully funding informal sector contributions from tax revenue (Akazili 2010). Ghana's proposal to implement a one-time NHIS premium payment (OTPP) for the informal sector could therefore be viewed in relation to broader attempts at achieving universal financial protection for the poor and informal sector workers.

2.8. The proposed one-time premium payment (OTPP) policy of Ghana

The main formal document that currently exists on the Ghanaian OTTP is the ruling National Democratic Congress (NDC) party manifesto of 2008 (then opposition) from where the policy issue originated. A number of reports, studies and conference presentations on the Ghanaian NHIS either made mention of it (Akazili 2010, MOH 2009, Asenso-Boadi, Agbeibor 2010, NHIA 2010b, Soors 2010, MOH 2010, Oxfam et al. 2011, NHIA 2010a) or presented the opinions of the writers on the policy issue (Agyepong, Orem & Hercot 2011). Much of the debate on the proposed policy is currently based on speculation as there is no policy document in the public domain on the content of the policy. The debaters seem to agree on the point that it may affect only the informal sector, and may be similar to that of a tax-funded system for the informal sector (Agyepong, Orem & Hercot 2011, Oxfam et al. 2011). It is important to note that the debates on the OTTP seem to have been influenced by local and international politics and ideological orientations (Agyepong, Orem & Hercot 2011). Part of the international community has called upon the Ghanaian government to

immediately implement the policy (Soors 2010, Oxfam et al. 2011). This is because they believe it will make NHIS funding progressive (Oxfam et al. 2011). Some have also argued that, its timing is wrong as Ghana is currently faced with limited ability to raise additional revenues, limited health infrastructure, personnel and equipment, and hence merely removing premium payments is not a guarantee that there will be equitable access to quality health care (Agyepong, Orem & Hercot 2011). A recent publication by Oxfam et al. (2011) also suggests that the World Bank is not in favour of the OTPP since the Bank currently promotes the Ghanaian NHIS as a model for other LMICs.

It has also been reported that actuarial studies, feasibility analysis and willingness to pay studies on the one-time premium policy have been done (NHIA 2010a), but none of the results of these studies has officially been made known to the public. Nevertheless, the 2009 NHIA annual report indicates that the results from such studies show that the policy will be sustainable and feasible and hence a road map has been designed but has not been released to the public.

Though this review has not identified any country that practices a health insurance system that includes a one-time premium, the review has revealed countries like Thailand who fully fund the health insurance contributions of the informal sector from tax revenue. Other countries such as Kyrgyzstan and Moldova have also adopted this strategy for universal coverage (Yang, Holst 2007, Akazili 2010). As in the case of Thailand, the fact that the one-time premium payment policy was an election promise gives an indication that at least there is strong political will to achieve universal coverage in Ghana. However, in Thailand the financial sustainability and technical feasibility of a tax-funded system for informal sector coverage was established long before it became an election campaign promise (Hanvoravongchai, Hsiao 2007). In the case of Ghana, though the need for an effective

strategy to extend coverage to the informal sector appears to have been established, and while some studies on the feasibility of universal coverage in Ghana have been undertaken (ILO 2006, NHIA 2010b), the results have not been made available widely and are not regarded as politically acceptable. Also, no research was specifically conducted on the feasibility and sustainability of the one-time premium policy proposal before it was made a campaign promise. Nevertheless, if it is feasible and financially sustainable to implement this policy, this perhaps could be a window of opportunity for Ghana to achieve the long awaited goal of universal financial protection. The absence of empirical data on the feasibility of this proposed policy is the motivation for this dissertation as it seeks to contribute information to aid the assessment of the feasibility of the proposed one-time premium policy, and its prospects and challenges for universal coverage. It intends to assess feasibility from the perspective of stakeholder understanding and views on the OTTP.

3. Stakeholder analysis techniques and actor dynamics in health care financing reforms within LMICs

3.1. Who is a stakeholder?

Stakeholders are policy actors (Walt, Gilson 1994). They are individuals, groups, organisations or networks that have an interest in a policy issue and the ability to influence the policy process (Brugha, Varvasovszky 2000, ODA 1995). Hence, stakeholders are not only those who are officially commissioned to formulate and implement policies, but all actors, whose interest may in one way or the other be affected by the implementation of the policy (Gilson, Raphaely 2008). Based on how positively or negatively a policy affects the interest of its key actors, stakeholders could be seen as winners or losers from a policy change (ODA 1995). They could either come from the internal or external environments within which the policy issue is being considered (Brugha, Varvasovszky 2000) and depending on the importance of their influence on the policy process, stakeholders are often

categorised into primary and secondary stakeholders or major and minor stakeholders (ODA 1995, Clarkson 1995, Freeman 1984, Frost 1995).

Stakeholders are said to either present themselves as visible or hidden participants of the policy process (Kingdon 1984) and their influence could either be active or passive. The visible and active stakeholders are often directly involved in the production, management, regulation or evaluation of the policy process (Novick, Mays 2001). They are either within or outside the state's bureaucracy (Tantivess, Walt 2008). If they are within the state's bureaucracy, they are either policy authorisers at the top, middle-level managers or street level bureaucrats interacting directly with beneficiaries of the policy at the lower implementation level (Erasmus, Gilson 2008). Those stakeholders outside the state's bureaucracy could either be interest groups such as medical associations, religious groups, private sector institutions, labour unions, civil society organisations and NGOs, the media or beneficiaries of the policy (Erasmus, Gilson 2008, Gilson et al. 2003).

Drawing on the above categorisations, this study identifies stakeholders on the basis of the interest an individual, organisation, department or institution has in a policy, their position or behaviour and attitude towards it, the power and the resources they can bring to bear on the policy process and their potential influence on the policy process (Brugha, Varvasovszky 2000). Specific stakeholders in the health sector would therefore comprise: international donors, national political leaders and legislators, public officials of the Ministry of Health and the Ministry of Finance, organised labour, private sector organisations, non-governmental organizations, civil society, and consumers of health services (Gilson et al. 2003, Schmeer 2000).

3.2. Stakeholder characteristics

Stakeholder characteristics refers to stakeholders' understanding of or knowledge of a policy issue, their interest, positions, powers and actual or potential influence on the formulation and implementation of the policy (Brugha, Varvasovszky 2000, Gilson et al. 2003, Schmeer 2000). In most cases, the stakeholder's interest and positions on a policy issue is driven by how s/he understands the policy concept and the purpose of the reforms. Hence, lack of clarity on policy goals, such as the goal of equity, can bring about confusion in the perceptions of stakeholders about a reform process (Gilson, Antezana & Bennett 2000).

The interest of a stakeholder relates to the perception of the stakeholder about the likely impact of a policy process on it, which could either be positive or negative (Thomas, Gilson 2004). Therefore, the extent to which a stakeholder will be affected by the implementation of a policy defines the interest of that stakeholder in the policy issue (Roberts et al. 2008). The interest a stakeholder has in the implementation of a particular policy issue can be determined by considering the advantages and disadvantages for the stakeholder as a result of the implementation of the policy (Schmeer 2000). It is, therefore, possible to assess and present the various levels of interest that different stakeholders have in a particular policy on an ordinal scale of low, medium and high interest (Varavasovszky, Brugha 2000). A stakeholder's interest in a policy could be driven by political, economic, professional or even ideological reasons (Gilson, Antezana & Bennett 2000). A single stakeholder could however, have multiple interests in a policy which could be clearly visible or hidden (ODA 1995).

Another important stakeholder characteristic is the stakeholder's position on a policy issue. Driven by the interest they have in a policy, stakeholders will tend to either support, oppose or remain neutral or non-mobilised on a policy issue. The level of support or opposition of a stakeholder for a policy therefore defines its position on the policy (Thomas, Gilson 2004).

A spectrum of positioning from strong support to strong opposition is usually used to illustrate the relative position of a stakeholder on a policy (Schmeer 2000). Data on the position of a stakeholder on a policy issue could be obtained from the opinion of the stakeholder or the opinion of other stakeholders about it (ODA 1995) or even from documentary sources.

Of considerable importance to stakeholder analysis is an examination of the power of a stakeholder to influence a policy. Though very significant in stakeholder analysis, power is often not critically examined, especially within LMICs (Erasmus, Gilson 2008, Gilson, Raphaely 2008). The power of a stakeholder is usually reflected in the stakeholder's ability to either facilitate or block the policy process (Thomas, Gilson 2004). Power is a tool stakeholders use to protect their interest (Erasmus and Gilson, 2008). Stakeholders derive their power from the nature of their organisations, their control over resources (budget or strategic resources), and their possession of legal authority, information, specialised skills or knowledge, leadership ability, connections with other powerful stakeholders like politicians and ability to influence public opinion (ODA 1995, Tantivess, Walt 2008, Weible 2006). In exercising their power, stakeholders can control the decision-making process, facilitate it, or weaken or negatively influence the policy and its implementation (Crosby 1991). Stakeholders' power can be categorised into: power as decision making; power as non-decision making and power as thought control (Lukes 2005). Stakeholders can use the first two forms of power to facilitate or undermine the implementation process of a policy and the third form is mainly used to influence the understanding and perception of stakeholders against or in favour of a policy. In a top-down view of policy implementation, policy authorisers at the top level of bureaucracy usually possess instructional powers that they can use to initiate policies and demand compliance but, within the bottom-up perspective, street-level bureaucrats comprising front-line policy implementers usually have discretionary

powers they can use to reshape, elaborate or even reject a policy (Hudson 2009, Lipsky 2010, Scott, Mathews & Gilson 2011, Hill 1984, Hill, Hupe 2002). For example, they can deliberately refuse to see patients or take long tea breaks (Erasmus, Gilson 2008). This study adopts a mixed perspective (both top-down and bottom-up) of policy implementation.

Depending on the power and position of stakeholders on a policy, we could examine the influence stakeholders have on a policy by categorising them into policy drivers comprising those with high power and high support, supporters who have low power but high support, blockers who have high power but low support for the policy and bystanders or abstainers with relatively low support and power (Hyder et al. 2010). Alternatively, examining the influence of stakeholders, in relation to their interest and power on a policy, Eden (1996) categorised stakeholders into players who have high interest and high power, leaders with high power but low interest, subjects with high interest but low power and the crowd who have both low interest and power with regard to the policy. Stakeholders can therefore be said to influence policies by driving the policy process, supporting or facilitating it, blocking it or sitting on the fence.

3.3. Stakeholder analysis

An analysis that examines the interest, positions, power, alliances and influence of various stakeholders on the policy process and the importance of such influences on the realisation of the policy's goals is therefore referred to as a stakeholder analysis (Schmeer 2000, Varavasovszky, Brugha 2000). This analysis could be done at any stage of the policy process (Reich 1995, Frenk 1995). It could even be done before the development of a policy document (Mehrizi, Ghasemzadeh & Molas-Gallart 2009). Depending on the purpose of the analysis, a stakeholder analysis could be done retrospectively to reveal the roles stakeholders played in the development of a past policy or prospectively to assist in the planning and

implementation of a policy change (Varavasovszky, Brugha 2000) and to identify which actors should be involved in the policy process (MDF 2005). Prospective analysis is future-oriented (Hyder et al. 2010) and hence can be used to assess the feasibility of a change process or to think through the acceptability of a proposed policy idea (Mathauer et al. 2008). There are, however, several different levels at which stakeholder analysis can be done: it can be done at the international, national, local and even the individual level and either by an individual or a team within or outside the organisation by whom the policy is being considered (Varavasovszky, Brugha 2000, Hyder et al. 2010). However, doing a stakeholder analysis as a group of both insiders and outsiders may offer greater opportunities for coming out with results that will be more acceptable to other stakeholders than if undertaken as an individual (Varavasovszky, Brugha 2000). The evolution and processes of carrying out a stakeholder analysis, its purposes and the various ways in which the outcome of the analysis can be used to inform policy has been quite widely documented (Brugha, Varavasovszky 2000, Schmeer 2000, Hyder et al. 2010) and so will not be repeated here.

3.4. Stakeholder dynamics on health care financing reforms aimed at universal coverage in Ghana and other LMICs

The key stakeholders with respect to health care financing policy (especially health insurance) in Ghana include: the president, the Ministry of Health (political-the minister, and civil servants), politicians (especially the two main political parties- NDC and NPP), labour unions (Trade Union Congress, and medical, dental, nurses and other health sector workers' associations), civil society organisations, the staff of the National Health Insurance Authority and international donors (Rajkotia 2007, Agyepong, Adjei 2008, Government of Ghana 2003). The two main political parties (NDC and NPP) that dominate the current Ghanaian multi-party democratic political system, have in recent times made health insurance central to their election campaign promises. This has often led to attempts by elected presidents to

formulate or modify health care financing policies in line with campaign promises. The Minister of Health is usually mandated to formulate health care financing policy in Ghana. The NHIA manages and coordinates the implementation of health insurance systems and also makes recommendations for the formulation of health insurance policies. The civil servants of the Ministry of Health and Ghana Health Service provide technical support for the formulation and implementation of health care financing policy respectively. Other key stakeholders are: the staff of the district mutual health insurance schemes, both public and private health workers (doctors, nurses, facility administrators etc) who are responsible for policy implementation at the local level, and the populace (both formal and informal sector workers) who are the ultimate beneficiaries of health care financing policies and who also bear the consequences of such policies (Government of Ghana 2003, MOH, 2004).

In Ghana, retrospective analysis of the introduction of the National Health Insurance system revealed differences in stakeholders' dynamics in the policy process (Agyepong, Adjei 2008, Rajkotia 2007). The studies have shown that the Ministry of Health (MOH) (political), the incumbent political party (then NPP) and politically connected consultants were very strong proponents of the policy process. The position of the private sector was between neutral and proponents, while the position of MOH (civil service) and donors was between neutral and opponents. However, the existing CBHIS were simply opponents while the main opposition party (then NDC) and labour unions were very strong opponents of the reform process (Rajkotia 2007). The opposition to the policy was mainly centred on either the policy process or certain aspects of the content but not the policy idea (Agyepong, Adjei 2008). This implies that, in principle, the policy idea was accepted by almost all stakeholders since the "cash and carry" (out-of-pocket payment) system was recognised by every Ghanaian as very problematic and needed to be replaced by a more humane system.

The then opposition NDC Party (current ruling party) and organised labour supported the policy idea but the opposition party strongly opposed the policy process arguing that the rapidity of the process was politically motivated while organised labour strongly opposed certain aspects of the content especially the deduction of 2.5% from their SSNIT contributions to fund the scheme (Agyepong, Adjei 2008, Rajkotia 2007). These opponents raised three main concerns: the NHI levy would increase the burden of taxes on Ghanaians; the SSNIT deductions could affect the sustainability of the pension scheme; and there weren't adequate health facilities and personnel to ensure equitable access to services under the system (Abbey 2003). In particular, the introduction of new forms of taxes like the additional VAT has often been associated with actor resistance in Ghana (Addison, Osei 2001). While organised labour arranged a few street protests against the policy and threatened to take the government to court, the members of the main opposition party after unsuccessfully debating against it in parliament boycotted parliamentary proceedings on the day the NHIS bill was passed (Abbey 2003). The opposition from organised labour was overcome when the government decided to exempt all SSNIT contributors from the payment of a direct premium to their DMHIS as compensation for using part of their SSNIT contributions to finance the scheme (Agyepong, Adjei 2008).

As regards stakeholders' influence over the policy process, it has been documented that the MOH (political), the then incumbent political party (NPP) and the politically connected consultants had high influence over the process. The influence of labour unions was between medium and high, but that of the opposition political party, donors, MOH (civil servants) and the private sector was just medium, while the existing CBHIS had low to medium influence (Rajkotia 2007). The political actors relied on their political power mandated by the constitution to control and drive the policy process. Though technical experts, such as the civil servants in the MOH, have technical knowledge, their power to influence the process

was weakened by the principle of political neutrality which is the guiding code of conduct for civil and public servants in Ghana (Agyepong, Adjei 2008). However, the majority of the intended beneficiaries, especially those within the rural informal sector, had very little knowledge of what was going on with regard to the policy development (Agyepong, Adjei 2008). In line with what has been noted by Howlett & Ramesh (2003), all those who had very strong influence over the NHIS development process were mainly proponents and wielded political power or had connections with political actors.

Also, in the analysis of health care financing reforms in South Africa, Thomas & Gilson (2004) identified the MOH, the unit responsible for health care financing reforms and the academic community as the key primary and clearly visible drivers of health insurance reforms. Their study revealed that the existence of differences between the reform drivers as well as opposition from other actors made it difficult to establish adequate support for the adoption of any form of contributory health insurance in South Africa. Those stakeholders with higher political status, such as the Minister of Health and the National Treasury and those connected to such political figures, had greater influence over the reforms. Other stakeholders were reported to have acted in a manner that would protect their interests. The National Treasury opposed SHI on the basis of its potential impact on the tax to GDP ratio, administrators of private health insurance schemes were concerned with the protection of their profits and commercial interest and trade unions also opposed SHI (Gilson et al. 2003).

It was also noted that technical experts had very limited influence over other health care financing reforms in South Africa and Zambia (Gilson et al. 2003). The public, front-line implementers and mid-level managers were reported to have greater influence over the implementation and success of some reforms in South Africa and Zambia at the time (Gilson et al. 2003). Many actors, including political parties and some policy analysts in South

Africa, were classified as non-mobilised which means they did not play an identifiable role in influencing the process of the policy reforms.

Concerns about financial sustainability are prevalent in health care financing reforms in LMICs. One example is the case of Kenya, where a national social health insurance fund (NSHIF) proposed by the government of Kenya and approved by parliament in 2004, has since not received presidential assent because the Minister of Finance deemed it financially unsustainable (Maliti 2005, Franker, Hsiao 2007).

Even in Thailand, despite widespread popularity of the universal coverage reforms among stakeholders, Hanvoravongchai & Hsiao (2007) report that a number of stakeholders still exhibited some opposition to it and raised concerns about certain aspects of it. They revealed that though the policy got the full approval of the Council of Ministers, medical professionals opposed a medical liability clause contained in it. Labour unions opposed the merging of their Social Security Fund with funds of the universal coverage scheme. Technical staff within the Finance Ministry raised concerns about its long-run financial implications and the possible impact of a tax-based programme on the debt burden of the country. Private providers also wanted a guarantee that they would benefit from the new system. However, since the policy idea was endorsed by all stakeholders, these concerns were readily addressed and enabled the policy to be rolled out.

Although the studies and policy experiences reviewed here revealed interesting actor dynamics in health care financing reforms, they were all retrospective in nature drawing data from various sources to explain what had already taken place. With regard to health care financing reforms, there is little in the literature on prospective analysis within the context of Africa (Gilson, Raphaely 2008). This study would therefore be of great significance as it is

prospective in nature. What has come out clearly in this section is the fact that universal coverage reforms usually affect actors' interests in different ways and, hence, there is always bound to be actor opposition to such reforms. The concerns and influences of actors therefore need to always be taken into consideration for the reforms to be successful.

4. Conclusion

In summary, this literature review has highlighted that universal coverage is internationally accepted as the primary goal of health care financing systems. It has two main components: universal financial protection and universal access to needed health service. While universal access to health care entails the existence of a health system that offers every resident access to health care according to need, universal financial protection which is the focus of this study is mainly concerned with the protection of individuals against costs from out-of-pocket payments for health care. To protect individuals and households against the catastrophic effects of out-of-pocket expenditure requires the adoption of prepayment systems such as taxes and/or contributory insurance for financing health care. However, neither a tax nor contributory health insurance system is a one size fits all model for universal coverage. The various forms of taxes and insurance systems are all instruments to achieve the goal of universal financial protection. However, those prepayment systems that are mandatory and involve pooling of funds from different sources offer greater opportunities for achieving universal financial protection than systems that mainly rely only on taxes or contributory insurance.

Globally, only a few countries have been able to attain universal financial protection. These are usually those countries with relatively large formal sectors, but for most low- and middle-income countries, it has been very difficult to extend coverage to the poor and informal sector workers via contributory insurance. Thailand has been able to cover its informal sector but

that was achieved only after they had changed from a contributory insurance model for the informal sector to a fully tax-funded system. The current focus in the universal coverage debate is therefore on how coverage within LMICs can be extended to those in their large informal sectors. The evidence in the literature points to the fact that it is difficult to enforce premium payments in the informal sector and that this has been responsible for the low coverage in that sector. The Ghanaian experience of enforcing NHI premiums in the informal sector is similar to that of the global experience. LMICs are still being encouraged to explore innovative strategies of extending coverage to the informal sectors of their economies. In this study, the Ghanaian one-time premium payment (OTPP) policy proposal is therefore examined in relation to these broader efforts to explore innovative ways of extending coverage to the informal sector within LMICs.

The literature also reveals that even universal coverage reforms that have widespread popularity still face some actor opposition. To be able to think through the acceptability and feasibility of universal coverage reforms, such as the proposed one-time premium payment policy, requires a prospective stakeholder analysis to explore the likely interest, positions, power and influences of various stakeholders on the policy process and implementation. However, such prospective stakeholder analyses of health care financing reforms within LMICs are seldom done. Since the proposed one-time premium policy is currently at the decision stage, this study, which is a prospective stakeholder analysis, seeks not only to generate information that will contribute to assessing the feasibility of the proposed policy, but also to contribute empirical information in filling this gap in knowledge of prospective analysis of policy experiences within LMICs.

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Universal financial protection through NHIS: A stakeholder analysis of the proposed one-time NHIS premium payment (OTPP) policy in Ghana**Author:** Gilbert Abotisem Abihiro**Affiliation:** An MPH student (graduating in Dec. 2011) of the University of Cape Town, South Africa and a Senior Research Assistant, Department of Planning and Management, University for Development Studies, Box 520, Wa, Ghana. **Tel:** +233 249325818; **Email:** gilbiro@yahoo.com**Qualification:** BA (Integrated Development Studies) Ghana, MPH (Health Economics) Cape Town***Key messages***

- Depending on the interpretation of its meaning and the design of implementation arrangements, a one-time premium payment policy has the potential for increased population coverage under insurance especially within the informal sector, equity in health care financing and hence universal financial protection..
- Due to the uncertainties surrounding the policy issue, many powerful stakeholders are yet to take clear positions on it, thereby making it difficult to conclude on its feasibility.
- Lack of stakeholder understanding of the policy concept, the financing and sustainability of the policy and excessive politicisation will be the main challenges to its successful implementation and hence there is a need to deal with these issues before its implementation.

Abbreviated running title: Universal financial protection in Ghana: A stakeholder analysis**Key words:** Universal coverage, universal financial protection, NHIS, one-time premium stakeholders, stakeholder analysis**Word count of full article:** Abstract: **295**; main text (excluding tables, figures, boxes and reference): **6,369**, **Total: 8,937**

² Note: The Journal requires that tables and figures are separated from the text but to facilitate easy reading for the purpose of this dissertation, they have not been separated

³ Though Health Policy and Planning prefers articles that are not more than 5000 words (for only the main text), the Guidelines for the MPH dissertation requires that the article is up to 8000 words.

Abstract

Extending coverage to the informal sector is a key challenge to achieving universal coverage through contributory health insurance schemes. Ghana introduced a mandatory National Health Insurance system in 2004 to provide financial protection for both the formal and informal sectors through a combination of taxes and annual premium payments. As part of its election promise in 2008, the current government (then in opposition) promised to make the payment of premium 'one-time'. This has been a very controversial policy issue in Ghana. This study sought to contribute relevant information to assessing the feasibility of the proposed policy by exploring the understandings of various stakeholders on the policy, their interests/concerns, potential positions, power and influences on it as well as the general prospects and challenges for its implementation. The data was gathered from a review of relevant documents in the public domain, 28 key informant interviews and 6 focus group discussions with key stakeholders in Accra and two other districts. The results show that there is a lot of confusion in stakeholders' understanding of the policy issue and because of the uncertainties surrounding it, most powerful stakeholders are yet to take clear positions on it. However, stakeholders raised concerns that revolved around issues such as: the meaning of one-time premium within an insurance policy, the affordability of the one-time premium, financing and sustainability of the policy as well as the impact of such a policy on equity in overall access to health care. Policy-makers need to clearly explain the meaning of the one-time premium policy and how it will be funded and critically consider the concerns raised by stakeholders before proceeding with further attempts to implement it. For other countries planning universal coverage reforms, it is important that the terminology of their reforms clearly reflects policy objectives.

Introduction

Universal coverage (UC) has globally been recognised as a goal of high priority for every health care financing system (WHO 2005b, WHO 2010). It entails universal financial protection and universal access to needed health services (McIntyre & Kutzin 2010). Prepaid contributory systems such as taxes and insurance, which involve fund and risk pooling, are widely accepted as the key instruments for moving towards universal financial protection (WHO 2005b, McIntyre et al. 2008). Few

countries, mostly those with large formal sectors, have been able to achieve universal financial protection through direct contributory health insurance systems (McIntyre 2007, Carrin & James 2004, Evans 2007, WHO 2005a). A key challenge of contributory health insurance systems in low- and middle-income countries is how to extend coverage to those populations outside the formal sector (McIntyre et al. 2008, WHO 2005a, Samson 2009, Hsiao 2007).

Ghana, a lower-middle income country took a bold step towards universal financial protection in 2004 when, in an attempt to fulfil its 2000 election promise, the New Patriotic Party (NPP) government introduced a mandatory National Health Insurance Scheme (NHIS) to replace out-of-pocket payments for health care called the 'Cash-and-carry' system (Government of Ghana 2003, MOH 2004). It was designed to cover both formal and informal sector workers concurrently through a combination of insurance premiums and taxes but with exemptions for children, the aged and indigents (MOH 2004). The main sources of funds to the NHIS are: a 2.5% National Health Insurance (NHI) levy, an additional value added tax (VAT); a monthly equivalent deduction of 2.5% of the payroll from each formal sector worker's contribution to the Social Security and National Insurance Trust (SSNIT) pension fund; interest from investments made by the scheme; an annual premium contribution from all informal sector workers and those formal sector workers who are not covered by the SSNIT pension scheme; and a registration fee paid by all NHIS subscribers to their respective District Mutual Health Insurance Schemes (DMHIS) with which they register. The premiums are supposed to be structured according to ability-to-pay (NHIA 2009), but due to difficulties in assessing households' income levels, a flat rate is charged by many DMHIS (McIntyre et al. 2008, Jehu-Appiah et al. 2010). Services are accessed via a valid NHIS membership identification card. Currently, the registered membership population is about 66% (NHIA 2010c, NHIA 2010a), though the population with valid NHIS cards is 50% (MOH, 2010). The tax component (NHI levy) contributes 69.5% of the total funding to the NHIS, SSNIT deductions 23.2%, informal sector premiums only 5.1% and other income constitute 2.2% of the total funds for the NHIS (Results for Development Institute & Adjei 2010). Studies show that many of those who are not yet covered under the NHIS are the poor and informal sector workers who have been reported to have problems with the annual premium payment

(Gyapong et al. 2007, MOH 2009, Oxfam et al. 2011, Akazili 2010, Asante & Aikins 2008, Ansah et al. 2009, Jehu-Appiah et al. 2011).

It is perhaps against the above background that in 2008, the NDC (then in opposition) in its election Manifesto promised to *“implement a Universal Health Insurance Scheme which will reflect the universal contribution of all Ghanaian residents to the Scheme. Our universal Health Insurance scheme will guarantee access to free health care in all public health institutions. It will be listed in the health insurance schedule, will not be district-specific and will allow for **one-time premium payment** for registration with the scheme.....”* (NDC Manifesto 2008: 68). Since coming into power in January 2009, the government has consistently indicated its commitment to implementing the one-time premium payment (OTPP) system, though there is currently no policy document in the public domain on it (NHIA 2010c, NHIA 2010b, MOH 2009). The one-time premium has since attracted lots of controversy in the Ghanaian media as regards its feasibility. However, no formal study on the perceptions and potential stance of various stakeholders on the policy issue has yet been published. This study therefore sought to contribute information to assessing the feasibility of formulating and implementing the proposed policy by exploring the perceptions (understandings) of various stakeholders about the proposed policy and assessing their interest/concerns, potential positions, power relations and influences on the implementation of the policy through a stakeholder analysis. The study also highlights the potential prospects and challenges for the formulation and/or implementation of the policy and hence its potential impact on achieving universal coverage and lessons that can be learned from this Ghanaian experience.

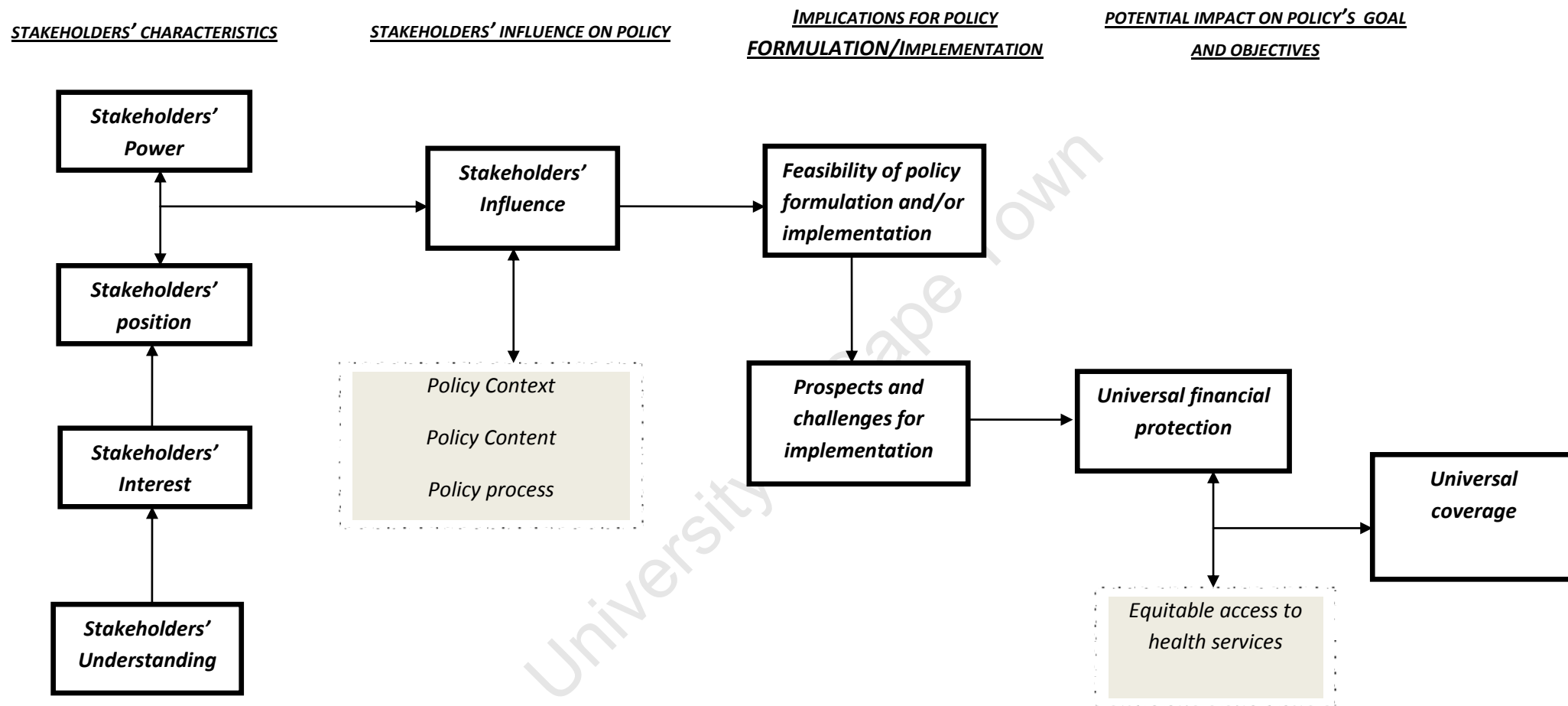
Conceptual framework

In this paper, it is postulated that stakeholders' understanding of the policy issue affects what they perceive as its impact on them (stakeholders interest), their interest influences their positions on the policy and drawing on the power they possess, stakeholders will seek to defend their interest by influencing the policy based on the nature of their position (see Figure 1). The interest of a stakeholder refers to the perception of the stakeholder about the likely impact of a policy on it, which

could either be positive or negative (Thomas & Gilson 2004, Roberts et al. 2008), or the advantages and disadvantages that will occur to the stakeholder as a result of the implementation of the policy (Schmeer 2000). Stakeholders' position refers to their potential support or opposition to the policy issue (Thomas & Gilson 2004, Brugha & Varvasovszky 2000), while stakeholders' power is their ability to influence a policy (Thomas & Gilson 2004) either at the level of policy formulation and/or implementation. This study is basically a stakeholder analysis with the emphasis on actor mobilisation around the policy issue. The study examined actor dynamics in relation to the overall formulation and potential implementation of the policy, drawing on issues about the potential policy content, the context and process of the policy as illustrated in the conceptual framework below.

University of Cape Town

Figure 1: Conceptual framework for analysing the potential influence of stakeholders on the proposed OTPP of Ghana



Methods

This was a qualitative cross-sectional study that explored the opinions of various stakeholders on the proposed one-time NHIS premium payment policy in Ghana. The data was collected between November 2010 and February 2011 in Accra - the national capital, Akuapim South district, an urban district in the southern part of Ghana and Kassena-Nankana West District, a relatively rural district in the northern part of Ghana. The data was gathered from three main sources to allow for triangulation (Mack et al. 2005, Silverman 2006). These were: face-to-face key informant interviews, focus group discussions (FGDs) and a review of media reports from 2008 to February, 2011. The key informant interviews were successfully administered to national level policy actors such as politicians of the ruling party- the chairman of the Parliamentary Select Committee on Health and a leading member of the NDC who is also a board member of the NHIA, opposition politicians- ranking member on health (NPP) and an opposition member of parliament, technocrats in the form of staff of the Ghana Health Service, academics - lecturers and health researchers, labour unions - leaders of Trade Union Congress (TUC) and Ghana Registered Nurses Association, and district level front-line policy implementers (staff of DMHIS - a scheme manager, public relation officers and claims managers, and health workers - a medical assistant, nurses, pharmacists, hospital administrator and accountants). The FGDs were conducted with NHIS (or potential) beneficiaries at the community level in the two districts. Stakeholders were selected through purposive and snowball sampling techniques due to the nature of the study and difficulty in easily identifying and getting access to the most important stakeholders respectively (Mack et al. 2005). However, because of the political sensitivity of the topic, some stakeholders (all staff of the ministries and NHIA and one DMHIS staff) did not consent to the interviews and hence their opinions were not obtained. Other national-level policy actors were willing to participate but were too busy to make time for the interviews. Notwithstanding the above, the views of policy actors such as the Minister (and deputies) of health, former directors of health services and civil society organisations that could not be obtained through interviews were captured from media reports. In all, 28 key informant interviews and 6 FGDs were carried out. The size of each FGD ranged from 9 to 11. Stakeholders were asked to give their own opinion and what they think will be the position/opinion of other stakeholders on the policy

issue. All interviews and FGDs were tape recorded, transcribed and analysed using thematic analysis with major themes derived from the conceptual framework of the study. The results are presented in tables, diagrams, boxes and on a force-field analysis map.

Results

Stakeholders' awareness and understanding of OTPP policy

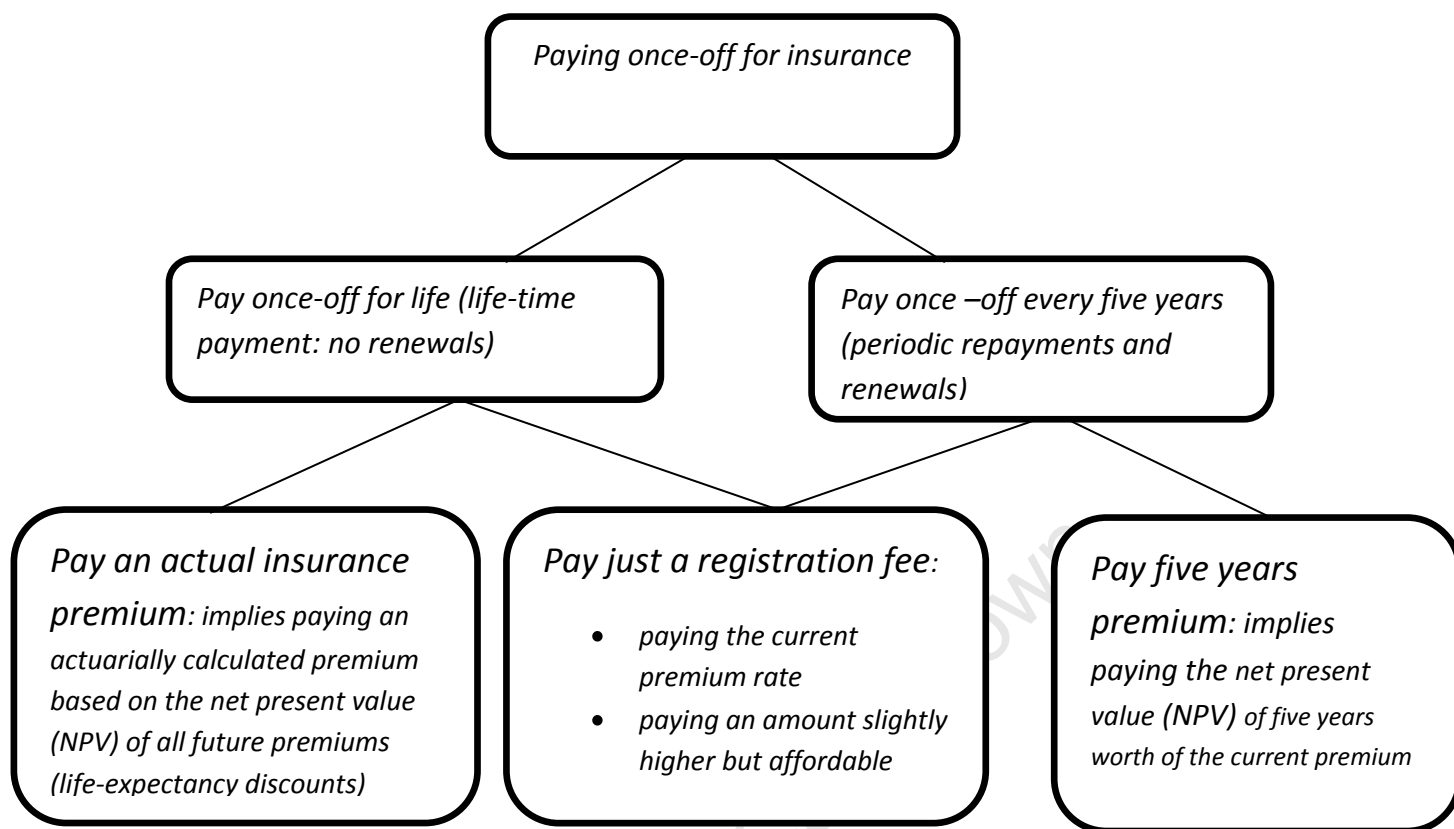
The results show that, there is a very high level of stakeholder awareness on the proposed OTPP policy.

The 2008 NDC manifesto and the electioneering campaigns, public statements by politicians and key staff of the NHIA, and radio discussions were reported as the main sources of information on the OTPP.

No gender differences were observed in stakeholders' awareness of the policy issue. The respondents in the urban district were, however, more aware of the policy issue than those in the rural area. This could be due to the intense political activities and better access to modern communication networks such as radio broadcasting that exist in urban areas.

It was also revealed that there was a lot of confusion regarding stakeholders' understanding of the proposed policy. This confusion is more intense among potential beneficiaries at the community level. Though almost all stakeholders reported no clear understanding of the proposed policy, a range of possible meanings as illustrated in Figure 2 were revealed from the explanations stakeholders gave on what they anticipate it to be.

Figure 2: Different shades of meaning of the proposed OTPP based on stakeholders understanding



Though the manifesto did not clearly state whether the OTPP entails life-time or periodic payments, what is often captured in the press and was reported by all the national level policy actors, many front-line policy implementers and some potential beneficiaries is that of life-time payments. Only a few health workers in the rural district and some potential beneficiaries felt it could entail paying once-off every five years. Most of those who reported the five-year cycles however thought the new national NHIS identity card system, which is valid for five years but renewable every year, was the same as the proposed OTPP.

Others were aware of the difference but argued that paying once-off for life is not feasible:

“I don’t understand the whole idea of the one-time. If you pay once and not pay again, then what will they use to buy drugs for us since we would not pay again? My understanding is that you pay again in five years time otherwise they won’t get money to buy drugs to treat us or the government will buy the drugs for us free?” (Woman, FGD, Rural).

However, as a form of life-time payment, the following box illustrates the understandings of stakeholders on what the OTPP system may look like.

Box 1: illustrations of forms of life-time OTPP	
<i>Paying just a Registration fee</i>	<i>Paying an actual insurance premium</i>
<i>A complete removal of informal sector premiums</i>	<i>It means premium payment will be maintained but paid for once to cover entire life time</i>
<i>Minimal (nominal) initial payment from the informal sector as a registration fee</i>	<i>Implies substantial initial premium payment</i>
<i>Health care in all accredited health facilities becomes free like existed in the 1960s</i>	<i>Those who can pay the accumulated amount will be covered and the rest will have to continue with the cash-and-carry system</i>
<i>No longer an insurance scheme but a publicly funded system (tax-based system)</i>	<i>The system will continue to operate as a life-time premium based insurance scheme</i>
<i>Government will have to raise additional funding elsewhere for the running of the NHIS</i>	<i>Premiums will be relied upon for the running of the scheme</i>
<i>The role of the NHIA becomes that of a third party payer</i>	<i>The NHIA maintains its current role</i>

The notion of paying the NPV of all future premiums was mainly held by opposition politicians, technocrats and some academics. Politicians of the ruling party, civil society organisations, most front-line implementers and potential beneficiaries expect that as a campaign promise, the OTPP will involve low payments (paying just a registration fee). Though the manifesto stated that the OTPP will provide free health care to all residents, neither the manifesto nor the policy-makers have clearly indicated how it will be financed. The policy idea also seems to put an emphasis on an insurance premium as it is called a one-time “**premium**” payment. There are currently therefore a lot of uncertainties with regard to how it will be financed. This confusion gets worse with the recent statement by the Chief Executive Officer of the NHIA that they are considering running a parallel system of OTPP alongside annual premiums and individuals will be allowed to belong to the one of their choice (Gadugah 2011). Technocrats, academics and opposition politicians were therefore of the opinion that even the policy-drivers are confused about the policy concept and argue that it is the name “one-time premium” that makes the policy issue unclear.

“From what the government is saying, the meaning is not clear but from my personal understanding, one-time premium payment is really not insurance, if it is just about paying a registration fee then that becomes like a National Health Service like akin to the British but if it

is about paying the premium one- time, then it means that they would have done the actuarial studies to be able to calculate how much you are supposed to pay till you die” (Opposition politician)

“I don’t understand it it is a political nonsense. It doesn’t conform to any health insurance, if it is a tax-based system, I would understand it but not under the National Health Insurance System” (Academic)

Stakeholder’s interest and potential positions on the proposed OTPP policy

Stakeholders’ interest and potential positions varied in relation to the two main meanings of the OTPP that were derived from their understanding of the policy issue.

OTPP as paying the net present value of all future premiums as a single payment

Stakeholders generally had similar interest/concerns and positions on this option. They generally feel this option will be unaffordable for many Ghanaians and hence it was clear that it is not likely that there will be any significant stakeholder support for an OTPP if it will result in amounts (premiums) that are significantly higher than the current premium. The reasons that stakeholders gave for their potential non-support for an OTPP in this form are illustrated in Box 2.

Box 2: Reasons for potential non-acceptance of an OTPP rate that is significantly higher than the current premium rate

It will be unaffordable to most Ghanaians, reduce the number of people on insurance, and make the NHIS pro-rich and inequitable

The electorate will feel deceived since they were promised free health care

It will be catastrophic and further impoverish many potential beneficiaries

It involves high risk as potential beneficiaries feel they may lose a lot if one pays and suddenly dies or a different government comes to change it.

It is strange in insurance policy and not practiced anywhere in the world

Paying a huge amount is not a guarantee that the quality of services received from providers will be improved

The amount that will be generated from the premiums alone will not be enough to run the scheme without subsidies from taxes

The NHIS have no capacity to efficiently manage the money over time.

It is therefore important to note that since this option was regarded by stakeholders as the least feasible option, the rest of the analysis presented here are based on the interpretation that the OTPP involves low payments.

OTPP as paying just a registration fee (low payments)

In relation to this, stakeholders showed varied interest in the OTPP. The positive issues that stakeholders raised were around its potential impact on population coverage under insurance and equity in access to health care. What stakeholders had doubts about was how it will be financed, sustained and operated efficiently. In general, those stakeholders that had negative concerns about it were more likely to be opponents, those that had positive views proponents and those who were not certain about its possible impact had conditional positions or were non-mobilised as illustrated in Table 1 below and the force-field analysis presented in the next section.

Table 1: Overall perceived impact of the OTPP on stakeholders and their potential position on the policy (if amount is low)			
Stakeholder	Overall perceived impact	Potential position	Key interest/concerns of stakeholders motivating stakeholder's overall perceived impact of policy and their potential positions
Politicians of the ruling party	Strongly positive	Very high support	They are the originators, initiators and drivers of the policy issue and implementing it will help them fulfil their campaign promise and make the NHIS more equitable and pro-poor.
Opposition political parties	Strongly negative	Very high opposition	Feels it is politically motivated and will only lead to an increase in taxes and the collapse of the NHIS because it will be economically unsustainable since the 1960s tax-funded public health care collapsed
Technocrats	Not Direct Slightly negative	Neutral - opponents	Neutral because they are civil servants but opponents because they are concerned about its feasibility, efficiency and sustainability
Academics	Not direct	Opponents and non-mobilised	Some are opponents because they feel the concept is strange in insurance policy parlance and may be unsustainable, but others are non-mobilised because they feel, depending on how it is designed, it can bring equity in health care financing
Labour unions	Not direct/ uncertain	Non-mobilised	Not sure if it can be sustained without increasing the burden of indirect taxes
Civil society organisations	Strongly positive	High support	It will relieve the poor of the financial burden of health care and promote equity in access to health care
Staff of DMHIS (permanent)	Uncertain	Non-mobilised	They feel it will increase NHIS coverage and may not necessarily affect the running of DMHIS if additional revenue can be mobilised to support it, but they are not sure of how it will be financed and whether there will be prompt transfer of centrally pooled funds to the scheme, and also concerned about their job security
Premium collectors	Strongly negative	Very high opponents	They may lose their jobs when renewal of premiums is taken away
Health workers (clinical)	Slightly positive	Support	It will enhance the welfare of their clients but their support may not be very strong because it may increase their workload and occupational stress
Health workers (administrative)	Not direct/ uncertain	Non-mobilised	They are not sure of its potential impact on claims payment and hence, internally generated fund.
Private pharmacist	Negative	Opponent	Opponents because it may collapse their business or delay claims payment, but their opposition may not be very strong because they are accredited to the NHIS and they also stand to benefit in terms of claims payment if the system works very well
(SSNIT contributors)- teachers	Not direct/ uncertain	Highly divided	Some may support it because it will relieve them of annual payments for their relatives; non-mobilised because they are not sure of its effect on tax burden; and opponents because they feel their contributions will continue to be deducted while those in the informal sector will not be paying
Informal sector workers	Strongly positive	High support	It will offer them unlimited financial access to health care and relieve them of the physical and psychological stress associated with yearly renewal of payments, but their support may not be extremely high because of fears that it can lead to poor quality of care and they also don't trust its continuation by subsequent governments because of the excessive politicisation of it.

Box 3 contains key quotations from stakeholders' responses that illustrate their interest and potential positions on the OTPP as captured in Table 1 above.

Box 3: Key quotations from stakeholders' responses that illustrate their interest and potential position on OTPP

"In as much as my re-imbursement will come regularly, I don't think it will affect my work" (Administrator, health facility)

"For us we do not think it is going to impact directly on us because we don't go out there to collect the money from the clients. We pick it from the insurance authority, so long as they have done their mathematics and they know that it is workable, we will always take our money from them. We don't crack our heads about how you want to raise the money, we take it" (Accountant, health facility)

"It is going to close down community pharmacies because doctors and nurses are saying that they must generate their internal fund (IGF) to support the health sector and because pharmacists are not prescribers and since every hospital has its own pharmacy, the clinicians would prescribe drugs that can be obtained from the public pharmacies and since with one-time premium many people may be under insurance, the business of community pharmacist will collapse" (private pharmacist, urban).

"We give a condition and we are not strongly against it, we only raise concerns about whether it will be sustainable. If it will be sustainable and we have means of ensuring that we don't bother Ghanaians with extra indirect taxes then of course we are in for it" (Trade Union Congress)

"Nurses need to have a clear understanding of the policy before taking a position on it. We are not sure whether it will work or not but if it will work we will support it" (Nurses Association).

Stakeholders' power and potential influence over OTPP

Assessment and mapping of stakeholders' power

An assessment of the power of stakeholders in relation to their ability to influence the formulation, implementation and/or overall success of the OTPP is illustrated in Table 2. The assessment was based on information gathered from stakeholders' opinions and secondary data from published studies (Agyepong & Adjei 2008, Rajkotia 2007). A mapping of the overall estimated power (in the entire policy process) of each category of stakeholder in relation to their positions to give an indication of their potential influence on the policy, if the OTPP will not result into amounts that are significantly higher than the current premium, is presented in the force-field analysis (Figure 3). It must be noted that in general, national level policy actors have greater potential power and influence over the formulation, front-line implementers over the implementation and potential beneficiaries over the success and survival of the policy.

Table 2: Procedural assessment of stakeholders power and ability to influence the formulation and/or implementation of the OTPP												
<i>Source of power/ influence</i>	<i>Legal mandate to initiate the policy</i>	<i>Voting power / influence over voters</i>	<i>Legislative power for policy approval</i>	<i>Control over state resources</i>	<i>Technical/ professional Knowledge/ skills</i>	<i>Involve in policy formulation / NHIA Board</i>	<i>Ability to influence public opinion</i>	<i>Ability to organise members</i>	<i>Past influence over state policy (NHIS)</i>	<i>Control over policy implementation at the local level</i>	<i>^αDetermine policy success and/ continuity</i>	<i>Overall estimated potential level of power</i>
<i>Ruling party politicians</i>	√√√√		√√√	√√√√		√√√√	√√√	√√√	√√√√		√√√	<i>Very high</i>
<i>Opposition parties</i>			√√				√√√	√√√	√√		√√	<i>Medium/High</i>
<i>Technocrats</i>					√√√√	√√√			√√	√	√√	<i>Medium/high</i>
<i>Academics</i>					√√√√		√√					<i>Low/medium</i>
<i>Labour unions</i>		√√				√√	√√√	√√√√	√√√			<i>High</i>
<i>Civil society Organisations</i>		√			√√		√√√	√√	√			<i>medium</i>
<i>staff of DMHIs (permanent)</i>					√√√		√			√√√√	√√	<i>Medium/High</i>
<i>Premium collectors</i>										√		<i>Very low</i>
<i>Health workers (clinical)</i>					√√√√		√√√	√√√	√√√	√√√√	√√√	<i>High</i>
<i>Health workers (administrative)</i>					√√√√		√	√√√	√	√√√	√√	<i>High</i>
<i>Private pharmacists</i>					√√√√		√√	√√	√√	√√√	√√	<i>High</i>
<i>Informal sector workers</i>		√√√√					√				√√√√	^β <i>Very high</i>
<i>SSNIT contributors</i>		√√√					√√	√			√	<i>Higher Medium</i>

^{Note} The no. of ticks implies level of power and potential ability to influence the policy. √√√√ implies very high; √√√ implies high; √√ implies medium; √ implies low and no tick implies no recognised power (potential limitation on the ability of the stakeholder to influence the policy)

^α Though the others sources of stakeholder power are self explanatory, ability to determine policy success and continuity refers to how a stakeholder's acceptance or rejection of the policy can directly affect policy sustainability and the realisation of policy goals.

^β Though informal sector workers do not have many ticks relative to some other stakeholders, their power mainly serves as a limitation to the power of other powerful stakeholders and is very key in the survival of the policy.

Figure 3. Force field Analysis: The potential power and positions of stakeholders (if OTPP is not significantly higher than current premium rate)								
STAKEHOLDERS' POSITION		Proponents			Opponents			
		Very high support	<<		Non-mobilised/conditional/neutral	>>		Very high Opposition
POTENTIAL STAKEHOLDERS' POWER	Very high ^ ^	Political party in government						
			Informal sector workers					
	Medium			Health workers (Clinical)	Labour unions Health workers - administrative Staff of DMHIS (permanent)	Technocrats	Accredited private pharmacist	Opposition parties
				(SSNIT contributors)	(SSNIT contributors)	(SSNIT contributors)		
			Civil society organisations		Academics	Academics		
	^ ^ Very Low							Temporary staff of DMHIS (Premium collectors)

Description of potential influence of stakeholders

From the force-field analysis, the party in government (politicians) is the main proponent of the OTPP and possess very high power. They have political and constitutional legitimacy to initiate the policy, a parliamentary majority to secure parliamentary approval and control over the economic resources of the state needed for the policy implementation. They may be limited by lack of technical knowledge to design and enforce its implementation and limited resources to make design and implementation possible. They will therefore have to directly involve technocrats who possess the technical expertise required for the design of the policy. These technocrats are, however, opponents of the policy issue but their influence may not be visible because of limitations imposed by the civil service code of conduct. They can still covertly influence the content of the policy. Hence, the policy-drivers may have to act cautiously when involving technocrats in the design of the policy.

If the policy-makers choose to act in the interest of the informal sector workers, who constitute the majority of the Ghanaian voters, by fixing a nominal amount for the OTPP, they may obtain their full support and the support of civil society organisations for the policy. By virtue of the fact that this policy issue is a political initiative and has been highly politicised, it will be the voting power of the electorate and their acceptance of it that will determine its ultimate survival. The informal sector therefore possesses a potentially very high level of power in relation to the survival and success of the policy since informal sector workers constitute the largest population of voters in Ghana and would be the direct beneficiaries of the OTPP. However, informal sector beneficiaries in reality have often not had much influence over social policy formulation in Ghana (e.g. with the establishment of the NHIS) (Agyepong & Adjei 2008). Their actual influence on the formulation of the policy may therefore not be high. A possible opportunity exists for an alliance between informal sector beneficiaries and civil society organisations (CSOs) as both may be supporters of the policy if the OTPP does not involve substantial payments. This alliance can give a voice to beneficiaries, increase their awareness level on the policy issue and their ability to influence the policy through an informed exercise of their political franchise, and also strengthen the power level of CSOs, which is currently medium. The two can

come together to strongly demand that government strictly goes by the social contract of providing free health care for all and by influencing voters' opinion. Also, some CSOs usually have technical expertise, financial resources and international connections to support policy implementation. They can therefore rally behind the government through advocacy and research or use their international connections to attract international funds to support the implementation of the policy.

As potential supporters, health workers (clinical) may be a key source of education on the OTHP to potential beneficiaries and may also encourage their patients to register with the scheme. But, since they are not strong proponents of the policy, if nothing is done to mitigate the increased workload and stress the policy will bring to them, they may turn to behave rudely to insured clients (such as deliberately delaying seeing patients, shouting at them, going on long breaks etc) (Erasmus & Gilson 2008). Local-level health workers generally possess professional knowledge and interact directly with patients and are therefore at the centre of the successful implementation of the policy. With their discretionary powers, they can undermine or facilitate the implementation of the policy by their behaviour towards insured clients (Hudson 2009, Lipsky 2010) and hence they have a high power to influence the policy.

Apart from technocrats, potential opposition to the proposed policy may come from the opposition political parties, accredited NHIS private pharmacists and the NHIS premium collectors. The premium collectors may have very little influence over the policy because their power is very low. As the main opponents, the opposition politicians may try to block its passage into a law and its subsequent implementation, but their power may be limited by their lack of a parliamentary majority, and they must also act in the interests of the electorate. However, as a vibrant opposition in parliament, they can influence public opinion, especially that of their supporters, against the policy and may strongly resist and delay its passage into law. The policy may finally be passed without parliamentary consensus. However, they may not continue with its implementation if they happen to win the next political election which is due in 2012. Also, with their potentially high power, if the NHIS accredited private pharmacists realised that the OTHP will result in delays in payment of their

claims, they may withdraw their accreditation with the NHIS and encourage insured clients to continue to buy drugs out-of-pocket from them, since they are located close to clients and interact regularly with them. They may also remain accredited with the scheme but fraudulently over bill customers in order to make more profits and this can affect the financial sustainability of the scheme.

Most stakeholders with potentially medium to high power currently have no clear (certain) positions on the policy and their influence may therefore be conditional on the content or design of the policy. If the labour unions perceive that the policy will not be sustainable without an increased burden of taxes, they may organise their members to demonstrate against it or form an alliance with other opponents to oppose it. Their power is high because they are well organised, have control over their members in formal sector employment and the Trade Union Congress (TUC) is represented on the NHIA board.

The permanent staff of the DMHIS can influence the overall implementation of the OTPP at the district level. If it is clearly proven that implementing it will not affect the sustainability of the scheme, they will become strong proponents of it and hence will facilitate its implementation by giving effective client education on the policy, preventing fraud and ensuring that clients and providers are fully satisfied with the services received from them. However, if they perceive that its implementation will negatively affect the operations of the DMHIS, although they may not be able to openly oppose it because they are civil servants, they may secretly undermine its implementation by deliberately delaying claims processing and payment and issuance of membership cards or poor treatment of clients. Also, the influence of health workers (administrative) will depend on how promptly their claims will be paid under the OTPP. Health facility administrators have control over health facilities and hence can withdraw services provided to insured clients and demand out-of-pocket payments from clients if the scheme is unable to pay their claims.

Academics and formal sector employees are the groups that appeared to be divided on the policy issue. Academics generally possess academic and technical knowledge on the policy issue, however, they are not organised and often not directly involved in the policy process and hence they usually

have low influence over health care financing policy (Agyepong & Adjei 2008, Rajkotia 2007, Gilson et al. 2003). Notwithstanding this, those who are currently opponents can influence public opinion against it through their prolific writings or public discussions in the media. The non-mobilised may become supporters depending on how the policy will be designed. Though formal sector workers are a more organised and educated population than the informal sector premium contributors, their power may not be as high as that of the informal sector workers as illustrated on the force-field analysis map in determining the success of the policy since they may not be the direct target of the policy. If their leadership accepts the policy, they may not individually be able to influence. However, they could be key sources of education on the policy at the local level (especially teachers).

The prospects and challenges for OTPP's formulation/ implementation and hence universal coverage

Table 3 summarises the opinions of stakeholders on the prospects and challenges for the formulation and/or implementation of the proposed OTPP and hence universal coverage, and the recommendations stakeholders made for consideration.

Table 3: The prospects and challenges for formulating and/or implementing OTPP idea and hence universal coverage

Issue	Prospects	Challenges	Recommendation⁴
The policy idea	<i>It is in line with international calls for efforts to extend financial protection to the poor and informal sector workers</i>	<i>Lack of clarity on the policy concept has led to confusion among stakeholders and hence uncertain stakeholder positions on the policy issue</i>	<i>Policy-makers should be clear on the definition of the OTPP. If it is to be implemented there must be effective public education on the policy</i>
Sources of funds for implementation	<i>Can rely on proceeds from oil revenue</i> <i>Can increase NHI levy, increase sin taxes on alcohol and tobacco, let corporate bodies pay NHI levy</i> <i>Seek support from donors</i> <i>Increase budgetary allocations to NHIS</i>	<i>Oil revenue is not reliable because it is a finite resource and oil prices are not stable</i> <i>Introduction of new taxes may be resisted</i> <i>The donor community does not contribute much to the current NHIS and hence, cannot be relied upon to support an OTPP. Government has a limited ability to raise additional revenue</i>	<i>Government should be honest and tell Ghanaians that it will be tax-funded. Hence, fund it from (earmarked) indirect taxes</i>
Feasibility for implementation	<i>Premium constitutes a small proportion of NHIS revenue (about 5%) and hence removing it may not negatively affect the NHIS.</i>	<i>It will be difficult to determine an affordable one-time premium</i> <i>There is inadequate technical and administrative capacity to run it</i> <i>Difficult to obtain the support of all stakeholders for the policy</i> <i>Poor identification system and data base on population and disease burden makes it difficult to predict future health care cost</i>	<i>Results of feasibility studies on it should be released for public assessment</i> <i>The national identification exercise should be completed and birth and death registration improved before its implementation</i>
Impact on Population coverage	<i>If the premium is affordable, more people will be enrolled into the NHIS</i>	<i>If the premium rate is high, it will reduce the number of people under NHIS</i>	<i>The OTPP must not be significantly higher than the current premium</i>
Impact on Financial protection	<i>Can reduce the level of out-of-pocket payments (OOP) if many are able to enrol</i>	<i>If the number of people on insurance reduces, the cash and carry system may re-emerge or if there are delays in claims payment, providers will charge informal fees</i>	<i>Ensure that claims under the OTPP are paid promptly</i>
Impact on Equity	<i>If it is tax-funded, it will improve progressivity in health care financing as informal sector premiums are currently regressive while VAT and direct taxes are progressive in Ghana (Akazili 2010), and the poor</i>	<i>If the initial payment is substantial, the NHIS will become more regressive and pro-rich in enrolment</i>	<i>Make the premium rate affordable and ensure that exemption from making the OTPP for the poor and vulnerable is effectively implemented</i>

⁴ The recommendations are based on stakeholders' views. Not all are therefore necessarily in line with the personal opinion of the author on the policy issue.

	<i>will enrol and also benefit from the tax subsidy to the NHIS</i>		
Politics and political commitments	<i>Because it is a political campaign promise, the current government will be committed to its implementation</i>	<i>People do not trust that subsequent governments will be committed to its sustainability since it has been highly politicised</i>	<i>Its implementation should not be rushed. Depoliticise it. The public must be adequately informed about the policy design and informed public debates should be fostered.</i>
Financial sustainability	<i>Generally doubted by stakeholders</i>	<i>It may be difficult to sustain in the event of economic difficulties since the Ghanaian population grows faster than the economy</i> <i>A tax-based system was previously introduced in Ghana but could not be sustained</i> <i>Actuarial studies reveals that even without the OTPP, the NHIS reserves will be depleted by 2016 (Adu-Gyamerah 2010)</i>	<i>Carry out more independent studies to establish its long-term financial viability</i> <i>or</i> <i>Maintain the current system and only identify the poor and indigents to make a one-time registration with continued payment for this group from tax revenue</i>
Impact on access to health care	<i>If affordable, it can increase financial access to health care and hence increase utilisation of health services</i>	<i>Limited health facilities and personnel can lead to overcrowding, poor attitude of health personnel and a general poor quality of services. There will still be spatial inequities in access to health services since facilities are not evenly distributed</i>	<i>Before implementing the OTPP, more health personnel need to be trained and out-migration checked. Health facilities should also be expanded and more established in underserved areas</i>
Impact on efficiency in the use of health services	<i>Can check demand-side moral hazard since, it can prevent people from seeking health care just because their cards are near expiring and hence feel their money will go to waste if they don't use the card within the year</i>	<i>If tax-funded, it can lead to "unnecessary use" on the demand side and supply-induced demand (SID) on the supply side, and a loss of ownership of the scheme by clients and clients may not value the services received under the OTPP</i>	<i>Capitation should be implemented to limit SID Proper primary care gate keeping should be enforced under the OTPP Introduce periodic renewals with minimal payments to give a sense of ownership</i>

Discussion

It must be noted that since the debate on the OTPP is ongoing, the opinions of stakeholders may change as fresh information on the policy issue is released to the public. The findings of this study may therefore not hold beyond the time frame of the data collection period. Besides, because of the absence of a policy document at the time of the study, the views captured in this study could have been misinformed. Also, because the policy issue has been ill-defined and the fact that the study

combined information on policy formulation and potential implementation, the stakeholder analysis has not exclusively focused on each distinctive stage of the policy process. The study therefore does not clearly reveal the potential difference in actor dynamics that may exist at different stages of the policy process. These are however peculiar problems with prospective stakeholder analysis of this nature (Thomas & Gilson 2004, Brugha & Varvasovszky 2000, Varvasovszky & Brugha 2000). Despite the above limitations, there are important findings in relation to the study objectives and conceptual framework that can inform policy-makers on the opinions of a wide range of stakeholders on the proposed OTPP, and lessons from the Ghanaian experience can inform future universal coverage reforms within Ghana and other LMICs.

One of the key findings of this study is that though stakeholders are highly aware of the proposed policy, there is currently lots of confusion in their understanding of it. This perhaps is because the policy issue was not made very clear in the NDC election manifesto and has not subsequently been well communicated to the public. Also, some stakeholders cannot understand how an insurance scheme will be run on a one-time premium basis.

This confusion in stakeholder understanding has led to several interpretations and likely misinterpretations of the meaning of the concept OTPP. The varied understandings of stakeholders offer some policy options for an OTPP. These include: An OTPP which involves paying an actual life-time premium calculated as the net present value of all future premiums; an OTPP based on a free health care model (tax-funded) requiring only nominal direct payments for registration; and an OTPP that takes the form of either the first or second options but renewable every 5 years. The third option is not a mutually exclusive policy option but it raises an issue for policy consideration as regards whether there is the need for periodic renewals of the insurance membership ID card within an OTPP. While some may argue that due to the absence of an effective national database and system of identification, periodic renewals may be necessary for updating the membership status of the NHIS under the OTPP, others may however, argue that if there will be no regular payments of the premiums, incurring an extra cost to renew the membership ID card may not be necessary.

The first two forms of stakeholder understandings had great influences over the interests and positions of various stakeholders on the policy issue. Stakeholders generally view the first option as “*a non-starter*” because it will be unaffordable and a diversion from the campaign promise which put emphasis on access to free health care in all public facilities. Most stakeholders will, therefore, not support its implementation and it is not likely that it will be feasible to implement the policy if it will result in premiums that are significantly higher than the current premium rates. This policy option may therefore have an overall negative impact on universal financial protection since it may shift many people out of insurance, increase out-of-pocket expenditure on health care and widen inequities in access to health care.

The second option was considered more realistic but stakeholders still had various concerns about a solely tax-funded OTTP. For the politicians, their interest seems to be more on how it will affect their political fortunes; for the technocrats, its effects on the sustainability and efficiency in the operation of the scheme; for academics, it is contrary to their understanding of the concept ‘insurance’ but is favourable in terms of equity in health care financing; for frontline implementers, its effects on their occupational and/or professional stability; and for civil society organisations and beneficiaries, its effects on beneficiaries’ ability-to-pay and equity in access to health care. The positions of stakeholders on this option therefore vary according to what they perceived as its likely overall impact on their interest. Those stakeholders in the political stream seem to have clear perceptions of its impacts on their interest and hence have clearer positions on it. This perhaps was a reflection of the general politicisation of the policy issue. But, due to the uncertainties surrounding the policy issue, most powerful stakeholders were generally not sure of how it will be financed (what taxes or public funds would be used) and sustained. Hence, stakeholders such as labour unions and front-line implementers (the staff of the DMHIS and health workers) with high discretionary powers and whose behaviour can facilitate or undermine the successful implementation of the policy (Erasmus & Gilson 2008, Hudson 2009, Lipsky 2010), have not yet taken a clear stance on it. This makes it very difficult to conclude whether it will be feasible to implement the OTTP or not, even if it takes the form of a tax-funded system. It is however clear that the positions of most of those stakeholders are conditional

on the amount that will be fixed as a one-time premium, the sources of funds to support it and evidence on its financial sustainability. These are therefore issues that should be given critical attention in the preparation of the policy as they will be key in determining the feasibility of a tax-funded OTPP and its overall prospects for achieving universal financial protection.

Stakeholder dynamics with regards to the OTPP (especially at the level of policy formulation) may therefore not differ so much from what was reported during the introduction of the NHIS since political figures are still likely to have the greatest influence over the policy process (Agyepong & Adjei 2008, Rajkotia 2007, Howlett & Ramesh 2003). The only difference may be that potential beneficiaries are more aware of the OTPP debate than the debates with regard to the introduction of the NHIS (Agyepong & Adjei 2008) and are very interested in the policy issue because of its potential impact on the benefits they currently enjoy from the NHIS. In general, the following implications can be drawn from the findings of this study for future universal coverage reforms in Ghana and other LMICs.

Firstly, though political campaign promises offer windows of opportunity for moving towards universal coverage as happened in Thailand (Tangcharoensathien et al. 2011, Jongudomsuk 2007, Hanvoravongchai & Hsiao 2007), those campaign promises in themselves are potential sources of actor opposition to intended policy reforms, if the policy process is not managed well. A considerable part of the confusion on the OTPP is perhaps due to the fact that it was a campaign promise that may bring political advantage to a particular political party if implemented or not. This political rivalry between the two main political parties, NDC and NPP, was even reported in 2003 with the introduction of the NHIS, which was also a campaign promise by the NPP (Agyepong & Adjei 2008). It may therefore not be surprising that, as the OTPP was also as a campaign promise by the NDC, members of the NPP may oppose it on political grounds. On the other hand, it also implies that the policy initiators may also tend to consider the concerns of the opponents as mere political propaganda without critically looking at the substance in their arguments. The broader implication of this is a lack

of consensus on the initiation of universal coverage reforms which becomes a threat to the continued existence of political will for policy sustainability in the event of a change in government.

Also, the terminology of universal coverage reforms in themselves are potential sources of confusion about intended reforms. The name “one-time premium” is central to the confusion on the policy issue. Reforms bearing unfamiliar titles like one-time premium usually do not capture clearly the objectives of the reform and hence lend themselves to misinterpretation. This confusion with concepts used in universal coverage reforms was also recently reported in South Africa, with the term NHI being used in their recent proposed health care financing reforms for a system that will be tax-funded (McIntyre 2010). This is because people usually understand the concept of insurance to mean a system that is operated on the basis of renewable premium payments (Kutzin 2007) and hence any system that challenges this belief system of stakeholders will generally be resisted (Weible 2006). Other scholars however argue that insurance does not necessarily mean the existence of an insurance scheme that people make direct payments to, but as indicated by Gupta can refer to any financing arrangement that *“can help defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households”* (Gupta 2007: 111). This implies that even a fully tax-funded or what is often called a “free” health care system also serves as an instrument for achieving the insurance objective (Kutzin 2007).

In reality, if the OTPP is intended to be a single payment of net present value of all future premiums, it is a strange concept as there is no evidence of any country that has ever successfully implemented such a system. However, using tax revenue to fully fund the contributions of the informal sector is not strange as countries like Thailand have achieved universal coverage under such a system (Tangcharoensathien et al. 2011, Jongudomsuk 2007, Tangcharoensathien et al. 2007). Other countries such as Kyrgyzstan and Moldova have also adopted this strategy for universal coverage (Kutzin et al. 2009, Yang & Holst 2007). The South African NHI proposal is also similar to this option (McIntyre 2010). What is more important is that the tax-funded approach is currently viewed as the fastest way to achieve universal coverage because of the international recognition that

enforcing premium contributions in the informal sector has often not been effective (WHO 2010, WHO 2005a, Samson 2009). The fruitless debate about terminology should be ended by the government clearly stating its policy design intentions.

Also, the Ghanaian historical experience of health care financing has an influence on stakeholders' perceptions about the merits of the intended OTPP. Stakeholders were generally afraid that if the OTPP entails paying just a nominal registration fee, the country may be taken back to the free health care system of the 1960s, which some stakeholders argued was abandoned because it could not be sustained (Ramachandra & Hsiao 2007, Agyepong et al. 2011). On the other hand, if it is not affordable then the "cash and carry system" may become even more widespread in Ghana. The desire to do away with out-of-pocket (OOP) payments is seen as a major requirement for moving towards universal financial protection and hence this argument is in line with the current debates for the prospects of universal coverage (WHO 2010, Evans 2007, Mathauer 2009). This is because empirical evidence has shown that OOP payments negatively affect utilisation of health services and has led to inequities in financial protection and the impoverishment of many households in those countries where they exist (Asenso-Okyere et al. 1998, McIntyre 2006, Xu et al. 2006, Lagarde & Palmer 2008, Waddington & Enyimayew 1989, van-Doorslaer et al. 2006). However, the claimed failure of tax-funded systems is still debatable as some may argue that there is no documented empirical evidence that such systems really failed. This is because they were abandoned in favour of user fees and health sector privatisation, as a conditionality of the World Bank and the IMF under the Structural Adjustment Programme (Russell et al. 1999, Gilson & Mills 1995, Sahn & Bernier 1995, World Bank 1993). In the case of Ghana, the major problem with the 1960s tax-funded system perhaps was insufficient budgetary allocations to the health sector. That could partly be explained to be due to the absence of an earmarked tax like the current NHIS levy for health care and hence health was sometimes marginalised in terms of budgetary allocations (MOH 2004).

Conclusion

Though an OTHP potentially can lead to increases in NHIS coverage especially within the informal sector if it does not involve substantial initial direct payments, the feasibility for its implementation and sustainability will largely depend on how it will be designed. Lack of stakeholder understanding of the policy concept and excessive politicisation will be the main challenges to its implementation. It is therefore not possible to conclude whether it is currently feasible to implement the policy or not since many powerful stakeholders are very uncertain about its impact and hence have not taken clear positions on it. The government and the policy-drivers need to clearly communicate to stakeholders what form the OTHP will take to enable Ghanaians engage in an informed debate on it. Also, the policy issue needs to be depoliticised and independent studies and public debates organised on it to examine its feasibility and long-term sustainability within the current Ghanaian economic context and historical experience of health care financing. The stakeholders' concerns captured in this study need to be critically considered before proceeding with further attempts to implement the policy. Those LMICs considering universal coverage reforms should be aware that terminology of reforms that do not directly reflect policy objectives can lead to confusion among stakeholders.

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Conflict of interest

None declared.

Ethical clearance

The study was given ethical approval by the University of Cape Town Research Ethics Committee, Cape Town, South Africa, and the Ghana Health Service Ethical Review Committee, Accra, Ghana.

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Universal health care coverage in Ghana: Focusing on the policy objective

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Introduction

This paper critically examines the main issues that are being raised by stakeholders concerning the proposed one-time NHIS premium payment (OTPP) policy in Ghana, in relation to international debates on universal coverage. Based on the evidence presented, the paper argues that the OTPP debate is currently more focused on the policy instrument of a one-time premium to the neglect of the policy objective of a universal health care system, which was stated in the National Democratic Congress (NDC) manifesto of 2008. The paper therefore calls for a more evidence-based debate, drawing on international experience and empirical research findings on how a truly universal health care system, which is the ultimate objective of health insurance, can be achieved, rather than just whether a one-time premium policy should be implemented in Ghana.

The evidence-base for this paper is drawn from a study conducted by the author about the views and positions of various stakeholders on this policy issue (Abihiro forthcoming). The data was collected between November 2010 and February 2011 through 28 in-depth interviews with politicians, technocrats, academics and labour unions in Accra, health workers and staff of two District Mutual Health Insurance Schemes (DMHIS), one in the north and the other in the south of the country, 6 focus group discussions with intended beneficiaries in the two districts, and a review of media reports on the policy issue.

International context of universal coverage debate

Member states of the World Health Organisation (WHO) committed themselves in 2005 to the implementation of universal health systems (WHO 2005b, WHO 2010). A universal health system aims at ensuring that all residents have adequate access to needed health care without being required to make (substantial) out-of-pocket payments for health care at the time of illness (WHO 2010, Carrin, James 2004). Health care financing systems that pool resources and risk through taxes and/or insurance contributions are the instruments for achieving universal coverage in health care (WHO 2010, Kutzin 2007). Evidence has however shown that contributory insurance schemes, as an instrument for achieving universal coverage, have been very difficult to implement among the poor and those who work outside the formal sector (WHO 2005a). Hence, coverage of the informal sector remains a major policy priority in international debates on universal coverage.

Historical context of health care financing in Ghana

During the colonial period, health care in Ghana was funded through out-of-pocket payments (Arhinful 2003). This restricted access to modern health services to a privileged minority because most people could not afford the fees. Immediately after independence in 1957, health care in all public facilities was fully funded from general tax revenue (Agyepong, Adjei 2008). This tax-funded system was not sustained due to economic recession in the 1970s which negatively affected government revenue and hence insufficient funds were allocated for health care. It was therefore abandoned in favour of the introduction of nominal user fees in the early 1970s and substantial fee payment at the point of service in 1985, popularly known as the “cash-and-carry” system, based on a loan conditionality imposed by the IMF and the World Bank under a Structural Adjustment Programme (SAP) (World Bank 1993, Gilson, Mills 1995). Under the “cash-and-carry system”, exemptions were introduced for the aged, pregnant women and the very poor, but they were ineffectively implemented

(Garshong et al. 2001, Nyongator et al. 1996). Community-based health insurance schemes emerged in the 1990s to replace this user fee system but they were limited in population coverage (Atim et al. 2001).

In 2004, arising from a campaign promise, a mandatory national health insurance scheme (NHIS) was introduced by the then ruling NPP to replace out-of-pocket payments for health care, with the ultimate goal of achieving universal coverage (MOH 2004). The NHIS is largely tax-funded with about 70% of its funds coming from a 2.5% National Health Insurance (NHI) levy placed on all goods and services that attract valued added tax (VAT) (NHIA 2010, Results for Development Institute, Adjei 2010).

Another source of NHIS funding is a monthly deduction equivalent to 2.5% of the payroll from each formal sector worker's contributions to the Social Security and National Insurance Trust (SSNIT) pension fund. Though some have referred to this payroll deduction as the premiums paid by SSNIT contributors (Agyepong, Adjei 2008, Wahab 2008), SSNIT contributors have been assured under the NHIS Act, ACT 650, 78 (3) that the deductions from their pension fund contributions will not affect their future pension payment (Agyepong, Adjei 2008, Wahab 2008). The pension payment will be based on the full 17.5% of payroll contributions to SSNIT and not the remaining 15% after the 2.5% deduction for the NHIS. In effect, the SSNIT component is a form of loan to government rather than a health insurance premium. Moreover, SSNIT contributors are exempted from making direct premium payments to their District Mutual Health Insurance Schemes (DMHIS) with which all Ghanaians are required to register. Only informal sector workers and those formal sector workers who are not covered by the SSNIT pension fund are required to make an annual premium contribution to their DMHIS before they are registered with the NHIS. Children below 18 years, the aged (70+), pregnant women, SSNIT pensioners and indigents are

entitled to NHI membership while being exempted from premium payments, though these exemptions have been poorly implemented. This implies that though every Ghanaian contributes to the NHIS through the NHI levy, an extra contributory burden is placed mainly on informal sector households. Those informal sector households who are not able to pay the insurance premium and who are not granted a premium exemption will therefore not have the opportunity of benefiting from the NHI levy and other government revenue channelled to the NHIS. A number of studies have revealed that the poor and informal sector workers are less frequently enrolled in the NHIS (Gyapong et al. 2007, Asante, Aikins 2007, MOH 2009, Ansah et al. 2009, Akazili 2010, Oxfam et al. 2011), partly because of the requirement to pay an annual premium (Akazili 2010). This calls into question equity in the current operation of the NHIS and the ability of the scheme to achieve universal coverage if the annual premium is maintained.

The proposed one-time NHIS premium payment (OTPP) policy

In 2008, the current ruling party (then opposition) made an election promise to implement a universal health insurance system which “*will guarantee access to free health care in all public health institutions*” (NDC Manifesto 2008:68). A one-time premium payment (OTPP) system was proposed as one of the instruments for achieving the policy objective of the free universal health care system. Policy-makers and the general public have, however, christened the intended reforms by its policy instrument, a “**one-time premium**”. Since there is currently no formal policy proposal in the public domain, the NDC manifesto remains the main official document on this policy issue. The policy issue has been very controversial and highly politicised within Ghana and internationally (Abihiro forthcoming, Oxfam et al. 2011, Agyepong, Orem & Hercot 2011).

OTPP debate

Evidence from my study (Abihiro forthcoming) indicates that there is no consensus among stakeholders with regard to the meaning of the one-time premium, what will be an appropriate amount for the OTPP and how the OTPP will be calculated. Some, mainly politicians of the ruling party, civil society organisations and informal sector workers, who are likely to have viewed the policy issue on the basis of its broader objective, argue that a one-time premium should require Ghanaians to pay a once-off token amount that is not significantly higher than the current annual premium level, in order to benefit freely from health care for their entire life-span. This implies that health care will be fully funded from government revenue. However, other stakeholders (mainly opposition politicians, technocrats and some academics) who perhaps focused on the policy instrument, argue that since the manifesto stated that it would be a premium (*one-time premium*), then it means that an actuarially determined premium (Nketia 2011) based on the net present value (NPV) of all future premiums will have to be calculated for a single life-time payment (Adu-Gyamerah 2010). It is not clear what the policy objective of such a payment would be.

It seems the policy-makers have also not been clear about the policy issue. Some political proponents of the policy argue that the one-time premium entails the provision of free health care (Koomson 2010), which will probably be funded from general public revenue such as taxes (Abihiro forthcoming) and part of the oil revenue (Gobah 2010). However, the Chief Executive Officer of the National Health Insurance Authority (NHIA) recently announced an intention to introduce a two-tier NHIS system, where the annual premium system will be allowed to run simultaneously with a one-time premium and membership to either tier will be based on choice (Gadugah 2011). This notion of a two-tier system seems to indicate that the one-time premium may not be affordable to every Ghanaian and again raises the question of what the policy objective of introducing a one-time payment in this form is.

My study shows that few stakeholders are likely to support an actuarially calculated OTPP based on the NPV of lifetime NHIS contributions, because it will not be affordable to most informal sector households (Abihiro forthcoming). Also, some opposition politicians have raised the concern that a two-tier system will create a class structure in Ghana and further widen inequities in access to health care (Gadugah 2011). It is perhaps against this background that fully funding the NHIS contributions of all non-SSNIT contributors (mainly informal sector workers) from government revenue was suggested by Akazili (2010) as the surest way of attaining universal coverage in Ghana. This has also been advocated by some civil society organisations in Ghana (Oxfam et al. 2011, Dadzie 2011). Moreover, this seems to be in line with the current international debates and experience on universal coverage (McIntyre 2010, Tangcharoensathien et al. 2011).

However, many scholars have highlighted the need to pay attention to the important role a country's unique historical, socio-economic, political and environmental conditions play in the success of health care financing reforms when recommending or debating universal coverage reform options for LMICs (WHO 2010, McIntyre 2010, Mills 2007, McIntyre, Kutzin 2010, Wagstaff 2010). It is therefore the peculiar Ghanaian context that should be critically considered in the design of the OTPP policy, with a specific focus on whether and how the OTPP can contribute to achieving universal coverage.

A debate focusing on the policy objective

The current debate in Ghana should be focused on how the policy objective of a universal health care system can be achieved. The debate should be directed at what would be the most efficient and equitable way of funding coverage for the non-SSNIT contributors (specifically informal sector) in order to achieve universal coverage. Ghanaians need to debate whether the current annual premium system should be maintained or tax revenue should be used to pay

for those outside the SSNIT pension scheme in order to achieve universal coverage. From the evidence gathered from my study and a review of existing literature, the following potential advantages and disadvantages can be raised about each of the options within the Ghanaian context.

If the current contributory premium system is maintained, the following may be the advantages:

- It will continue to provide an additional source of revenue for the NHIS. This is a flexible source of revenue that DMHISs depend on while they wait for transfers of tax-subsidies from the government through the NHIA to them.
- The collection of the annual premium is a source of employment for some people (premium collectors).
- Paying a premium may instil in clients a sense of ownership of the scheme and make them individually feel responsible for their health and health care.

However, the disadvantages of maintaining the current system include:

- The collection of premiums from the informal sector in Ghana is time-consuming, expensive and sometimes associated with fraud on the part of premium collectors (Akazili 2010), yet informal sector premiums only constitute about 5% of NHIS revenue (Results for Development Institute, Adjei 2010).
- The requirement of paying a premium for enrolment denies the poor and those in the informal sector, who cannot afford these payments and cannot secure premium exemptions, access to health care and benefits from the NHI levy and other tax subsidies to the NHIS.

- These contributions are very regressive since they are often fixed at a flat rate and hence impose a higher burden of NHIS payments on the poor.
- .On the other hand, the arguments that can be advanced for and against a fully tax-funded health care system include:
- It will promote equity in access to health care. This is because everybody contributes to taxes, especially indirect taxes, and hence everybody should also benefit from health care. A fully tax-funded system (particularly using indirect taxes) can therefore make the NHIS a truly universal health insurance system.
- Also, taxes are easier to collect than insurance premiums. Especially in the case of Ghana, where there is already a dedicated tax (NHI levy) for health care, a potential way forward for implementing a tax-funded health care system could be to increase this levy. This is not only because this levy through VAT is slightly progressive (McIntyre et al. 2008), but dedicated taxes in general can guarantee sustainable funding for health care since there is little flexibility for governments to relocate this revenue (Svedoff 2004).

Its disadvantages however include:

- Ghanaians are often not willing to accept additional (general) taxation (Addison, Osei 2001). However, people are more likely to accept payment of insurance premiums from which they receive specific health service benefits (Wagstaff 2010, McIntyre 2007).
- In Ghana, the transfer of funds from the central level to the local level is often associated with delays. If the annual premium payment is removed and transfers of tax revenue from the central level continue to be delayed, the payment of providers'

claims will also be delayed. If claims are not paid promptly, the revenue of health facilities will be negatively affected and this can lead to shortages of drugs at facilities since providers depend on such funds to purchase medicines.

- It may be difficult to sustain a fully tax-funded system in Ghana since the earlier one was not maintained. High population growth and associated increasing demand on publicly funded health services, economic instability and lack of citizens' trust in the continued existence of political commitment are the issues Ghanaians consider as potential threats to the sustainability of a fully tax-funded health care system.
- An inevitable increase in utilisation of health care under a fully tax-funded system in the midst of the current limited health care facilities and personnel will increase the workload of providers. This can lead to overcrowding at health facilities, delays in seeing patients, poor attitude of health providers towards clients and hence, can negatively affect the quality and efficiency of health service provision in Ghana.

The above are the issues that Ghanaians should be focusing on to contribute to a constructive debate about how best to achieve universal coverage. Notwithstanding the above, a creative exploration of not yet discussed alternatives could be built into the debate, keeping in mind questions that fit with the ultimate objective of universal coverage such as how to mobilize adequate revenue, how to expand coverage to all and how to protect the poor. The debate on these issues needs to be contextualised within the Ghanaian socio-political and economic setting. It should be driven by a clear understanding of the historical context of health care financing in Ghana and the realities of the design and operation of the current NHIS. Also, arguments need to be backed by evidence and not merely driven by what can be termed conventional wisdom.

In engaging in this debate, it is important to recognise that the core purpose for the current insurance contributions is to raise revenue from the informal sector. Given that there are other ways of generating revenue from this group, for example through indirect taxes, what would be the best way to raise this revenue? From an efficiency point of view, it is relatively more efficient to collect indirect taxes from the informal sector than insurance premiums. From an equity perspective, is it really feasible to identify those who are unable to afford insurance premiums in order to exempt them and provide financial protection and needed care to all residents or it is more feasible to collect revenue (e.g. through indirect taxes) from those in the informal sector with the ability-to-pay? It also needs to be explored whether collecting informal sector contributions through (earmarked) indirect taxes will really have an impact on (ownership) perceptions of the health system if residents are aware that the taxes paid by them are used to cater for their health care?

The other issues raised in the debate such as utilisation increases, possible misuse of health services and poor quality of care will exist irrespective of whether health care is funded from insurance premiums or taxes. Such issues therefore need to be addressed through other policy instruments; for example, addressing utilisation increases through primary care gate-keeping; and delays in transfers from the NHIA through improved fund management.

Conclusion

The Ghanaian debate on OTTP needs be refocused on how the intended policy objective of a universal health care system can be achieved instead of how a one-time premium will be implemented. Drawing lessons from international experience and debates on the feasibility of extending insurance coverage to workers outside the formal sector, the debate should be directed at whether the current contributory NHIS model for the non-SSNIT contributors (specifically the informal sector) should be maintained or the annual premiums should be

removed so that health care is fully funded from (potentially earmarked indirect) taxes. Switching to an earmarked tax-funded system is desirable and has greater prospects for universal coverage in Ghana given that most formal sector workers are already exempted from premium payments. But, as pointed out by some scholars, the current Ghanaian economic environment may not be favourable for its immediate implementation (Agyepong, Orem & Hercot 2011). It is therefore necessary that it should be at least considered as the strategic direction of the NHIS. The time to work towards this cherished goal is now. Every stakeholder needs to participate in the debate and this is the time for the academic community to contribute empirical evidence to the debate.

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PART E: Appendices

Appendix A: Data collection instruments

Interview Guide 1 (For the main policy drivers: Minister, CEO and Staff of NHIS and other top government Officials)

Date: ----- ID #: -----

Category of stakeholder-----

Organisation-----

Position in organisation-----

1. What is the one-time payment policy?
2. What would you say are the main reasons for implementing this one-time payment policy?
3. What are your views with regards to this policy (thus in terms of its advantages and disadvantages)
4. What do you think the impact of the one-time payment policy will be on the development of the Ghanaian National Health Insurance System? (probe for whether it will contribute to universal coverage or not and how)
5. Which stakeholders do you think are likely to support the implementation of the one-time payment policy?
6. Why do you think each of those stakeholders will support the implementation of the policy? (probe for what they stand to gain)
7. Which stakeholders do you think are likely to oppose the implementation of the one-time payment policy?
8. Why do you think each of those actors will oppose the implementation of the policy? (probe for what they stand to lose)
9. Do you think those stakeholders have the ability to influence the implementation of the policy? How? (probe for sources and level of power)

10. How easy do you think it will be for the one-time payment policy to be implemented in Ghana? (Probe for prospects and challenges of implementation)
11. What do you think needs to be done to deal with implementation challenges of the one-time payment policy?

Thank you very much for your time!!!!!!

University of Cape Town

Interview Guide 2– (Politicians, Legislators, Opinion leaders, Donors, Labour Unions)

Date: ----- ID #: -----

Category of stakeholder-----

Organisation----- Location-----

Position in organisation-----

1. Have you heard of the proposed one-time NHIS payment policy?
2. If so, how did you hear of it?
3. What do you understand a one-time payment to mean?
4. What do you think is the reason why the government wants to implement a one-time NHIS payment policy?
5. What do you think are the advantages and disadvantages of the one-time payment policy to the development of the Ghanaian National Health Insurance System? (Probe for whether and how it could contribute to Universal coverage)
6. What are your views on the one-time payment policy (are you in favour of it or not)?
 - a) I strongly support it ()
 - b) I somewhat support it ()
 - c) I do not support nor oppose it ()
 - d) I somewhat oppose it ()
 - e) I strongly oppose it ()

If stakeholder answers a, b, or c, continue with #7 but If stakeholder answers d or e, go to question NO. 8.

7. Only For those who answer “a,” “b,” or “c” to question #6:

- a) What is the reason for your support for the implementation of the policy?
- b) Are you able to demonstrate this support? If so, how?

c) Are there any conditions under which you will tend to oppose the policy instead of supporting it?

(If yes, probe for such conditions)

8. *Only For those who answered “d” or “e” to question #6:*

a) What is the reason for opposing the implementation of the policy?

b) Are you able to demonstrate this opposition? If so how?

c) Are there any conditions under which you will tend to support the policy instead of opposing it? (If yes, probe for such conditions)

9. Questions about other stakeholders who are likely to support the implementation of the policy

9 a. Which other organizations, departments within an organization or persons do you think will support the one-time payment policy in the way you defined it? (Probe for a list of stakeholders and their level of support)

9 b. What do you think would be the reason for the positions such stakeholders would take on the policy? (Probe for what each of the stakeholders would gain or lose from the policy implementation)

9c. Do you think that such stakeholders have the ability to influence the policy? (Probe for sources of influence and how stakeholder support will be demonstrated)

10. Questions about other stakeholders who are likely to oppose the implementation of the policy

10a. which other organizations, departments within an organization or persons do you think will oppose the one-time payment policy? (Probe for a list of stakeholders and the level of opposition)

10b. what do you think would be the reason for opposing the one-time payment policy from being implemented? (Probe for what each of the stakeholders would gain or lose from the policy implementation)

10c Do you think that such stakeholders have the ability to influence the policy? (Probe for sources of influence and how stakeholder opposition will be demonstrated)

11. Stakeholders 'opinions on possible policy options

Note: (Only read out the option that differs from stakeholders' understanding of the policy)

(WILL BE VERY FLEXIBLE HERE)

11a. If a one-time payment policy requires that citizens pay just an NHIS registration fee without NHIS premiums in order to benefit freely from health care for the rest of their life time, will you change your position (support or oppose) on the policy? How? And why? What about the position of other actors?

11b. If under a one-time payment, the present value of all future premiums is calculated for citizens to pay at once in order to benefit freely from health care for the rest of their lives, will your position (support or oppose) on it change? How? and why? What about the position of other actors?

13. How easy do you think it will be for the one-time payment policy to be implemented in Ghana?
(Probe for prospects and challenges of implementation)

14. If you were giving the opportunity, what will you suggest to the government in relation to the implementation of the one-time payment policy?

Thank you very much for your time!!!!

Interview Guide three (3)—(Staff of MOH, DMHIS, and GHS, frontline implementers (doctors, nurses and pharmacists)

Date: ----- ID #: -----

Category of stakeholder-----

Organisation----- Location-----

Position in organisation-----

1. Have you heard of the proposed one-time NHIS payment policy?
2. If so how did you first hear about the one-time payment policy?
3. What do you understand a one-time payment to mean?
4. What do you think will be the impact of a one-time payment policy on you and your organisation/profession as you defined it? (probe for impact on workload)
5. What do you think will be the disadvantages of a one-time payment policy to you and your organization/profession as you defined it?
6. What are your views on the one-time payment policy (are you in favour of it or not)?
 - a) I strongly support it ()
 - b) I somewhat support it ()
 - c) I do not support nor oppose it ()
 - d) I somewhat oppose it ()
 - e) I strongly oppose it ()
7. What is the reason for the position you have taken on the policy?
8. Under what condition would you change your position on the policy?
9. What do you think will be expected of you for the successful implementation of the policy?
10. **Questions about other stakeholders who are likely to support policy:**
 - 10 a). Which organizations, departments within an organization or persons/professions do you think will support the one-time payment policy in the way you defined it? (Probe for list of stakeholders)
 - 10 b). What do you think would be the reason for the positions such stakeholders would take on the policy? (Probe for what each of the stakeholders would gain or loss from the policy implementation)

10c). Do you think that such stakeholders have the ability to influence the policy? (probe for sources of influence and how stakeholder support or opposition will be demonstrated)

11. Questions about other stakeholders who are likely to oppose the implementation of the policy:

11a). which organizations, departments within an organization, or persons/professions do you think will oppose the one-time payment policy? (Probe for list of stakeholders)

11b). what do you think these opponents will gain from preventing the one-time payment policy from being implemented?

12. Stakeholders' opinions on possible policy options

Note: (Only use the option that differs from that of stakeholders' understanding of the policy)

12a. If a one-time payment policy requires that citizens pay just a registration fee without NHIS premiums in order to benefit freely from health care for the rest of their life time, will you change your position (support or oppose) on the policy? How? and why? What about the position of other actors?

12b. If under a one-time payment the present value of all future premiums is calculated for citizens to pay at once in order to benefit freely from health care for the rest of their lives, will your position (support or oppose) on it change? How? and why? What about the position of other actors?

13. How easy do you think it will be for the one-time payment policy to be implemented in Ghana? (Probe for prospects and challenges of implementation)

14. If you were giving the opportunity, what will you suggest to the government in relation to the implementation of the one-time payment policy?

Thank you very much for your time!!!!!!

Focus Group Discussion Guide: Community level and formal sector workers (SSNIT contributors)

Details of participants (to be filled in before discussions)

- Sex, educational qualification, NHIS membership Status, type of scheme registered with, duration with the scheme, district, region

1. Participants' awareness and understanding of one-time payment

- Have they heard of a one-time payment
- How did they hear about it?
- What do they understand a one-time payment to mean?
- What do they think is the reason why the government wants to implement a one-time NHIS payment policy?

2. Participant's expectations and interest in policy

- What do they expect from the one-time payment policy?
- What do they think is expected of them in a one-time payment
- What do they think would be the potential benefits of a one-time payment for them
- What do they think would be the potential disadvantages for them of a one-time payment

3. Participants positions on the policy (support or oppose policy) and reasons

4. Do they think they have the ability to influence the policy implementation? How?

5. Which other stakeholders do participants think would support the policy and why

6. Which stakeholders do participants think would oppose the policy and why?

7. Participants' opinions on various policy options

- a) Paying just a registration fee and would benefit from health care for the rest of their life time
(probe for positions and concerns of participants and that of others)

- b) Paying the present value of all future premiums at once in order to benefit freely from health care for the rest of their lives (probe for stakeholders positions and concerns and that of others)
8. What concerns or fears do participants have with regards to the implementation of the policy in general?
9. If given the opportunity, what will participants recommend for a successful policy implementation?

Thank you very much for your time!!!!!!

University of Cape Town

Data extraction sheet

A guide for extracting data from documents

Source/reference	
Stakeholder	
Understanding	
Interest	
position	
Reasons for position / concerns raised	
Power and power sources	
Likely influence on policy	
Perception of prospects and challenges for implementing the policy	

Appendix B: Consent Forms

Consent Form 1 – Interviews (key stakeholders)

This form will be read out to the participant before conducting the interview. After reading it out, the participants will be asked whether they have any questions or concerns about their participation in the study and if there are any concerns, they will be appropriately addressed before the interview. The consent form will be signed by the participant in the presence of the principal investigator. A copy of the consent form will be left with the participant.

General Introduction

You have been contacted to participate in a study on the proposed one-time national health insurance payment policy in Ghana. This study is being conducted by me, an MPH (Health Economics) student of the University of Cape Town in South Africa for my Masters dissertation. As an important stakeholder of health insurance issues in Ghana, it is important for me to obtain your opinion and that of your organization/institution/department on the proposed one-time payment policy. You are therefore being invited to participate in the interviews for this study which are administered to only key stakeholders.

Purpose and process

This study is conducted to explore the opinions of various stakeholders with regards to the one-time NHIS payment policy in Ghana. If you decide that you will like to participate in this study you will be interviewed by me. The questions that I will ask you are basically around:

- Your understanding of the one-time payment policy
- Your interest in the one-time payment policy
- Your position and concerns about the policy
- Your opinion about the position and concerns of other stakeholders about the policy

- What you anticipate the prospects and challenges for the implementation of the policy to be.
- Other interesting issues on the one-time payment policy that might come out during our discussion about the above topics

I plan to conduct about 30 to 35 interviews to produce a comprehensive report on the opinions of the major stakeholders on the policy. Each interview will take approximately 60 minutes.

Potential risks of your participation

There is very minimal risk of participating in this study. However, since the questions are about your opinion on the policy, I acknowledge that if the study makes known your opinion to the policy drivers or government, it may result into victimisation at the work place (if you are a staff/employee of MOH/NHIA) or damage the relationship between you/ your organisation and the government if your opinion is against the policy. The study however intends to address this by ensuring that all information gathered from these interviews are treated confidentially and the findings will be presented in a way that individuals/organisations will not be identified by names with their opinions.

There are however, no major psychological and physical stresses of participating in this study except that you may have to forgo other activities in order to respond to the interviews.

Potential benefits of the research

There are no direct material benefits to you as an individual of participating in this study. However, since the results will be made available to the National Health Insurance Authority to assist in finalizing the policy, this study offers you a potential platform to make known your opinion on the proposed policy issue. Also, your opinion and that of others, if taken into account by the policy drivers, will increase the possibility of coming out with a health insurance policy that will be widely acceptable to all Ghanaians. Hence your participation in this study offers wider benefits to the Ghanaian society.

Participation and withdrawal

Your participation in this study is voluntary. You can choose either to participate or not to. That is why your involvement in this study had been fully explained and you are asked to freely consent to it. You also have the option to discontinue your participation in the interview at any time without any adverse consequences.

Is there any other information you will like to know about the study?

Do you agree to participate in the study?

This study has been granted ethical approval by the Human Research Ethics Committee of the University of Cape Town, South Africa, and the Ghana Health Service, Accra, Ghana (see contact addresses below).

Should you have any questions after the interview you are welcome to contact the following:

Gilbert Abotisem Abihiro (Principal Researcher)

University for Development Studies

Faculty of planning and land Management

Post Office Box 520

Wa, Upper West Region, Ghana

[Tel: +233249325818](tel:+233249325818)

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Prof. Diane McIntyre (Supervisor)

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Anzo Road, Observatory 7925

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Diane.McIntyre@uct.ac.za

Human Research Ethics Committee

University of Cape Town, South Africa

Faculty of Health Sciences

Road, Observatory 7925

Cape Town, South Africa

Tel: +27 214066338

Ghana Health Service Ethical Review Committee

Research and Development Division

Ghana Health Service

Post Office Box MB 190

Accra, Ghana

Tel: +233 0302 681109

Statement of Consent (the one granting consent)

I declare that I have understood all that has been read out and explained to me. I am willing to participate in the study and I therefore grant my consent to participate in the study.

Signature Participant: -----

Date-----

Signature Principal Investigator -----

Date-----

University of Cape Town

Consent Form 2 – FGDs (community level beneficiaries and SSNIT contributors)

This form will be read out to the participants before conducting the FGDs. After reading it out, the participants will be asked whether they have any questions or concerns about their participation in the study and if there are any concerns, they will be appropriately addressed. The consent form will be signed /thumb printed individually by the participants in the presence of the principal investigator. A copy of the consent form will be left with each participant.

General Introduction

You have been contacted to participate in a study on the proposed one-time National Health Insurance payment policy (OTPP) in Ghana. This study is being conducted by me, an MPH (Health Economics) student of the University of Cape Town in South Africa for my Masters dissertation. As a potential beneficiary of the proposed one-time payment policy therefore, it is important for me to obtain your opinion as a group on the proposed one-time payment policy. You are therefore being invited to participate in the FGDs for this study which are administered only to potential beneficiaries of the proposed OTTP.

Purpose and process

This study is conducted to explore the opinions of various stakeholders with regards to the one-time NHIS payment policy in Ghana. If you decide that you will like to participate in this FGDs discussion. The issues that we will discuss are basically around:

- Your understanding of the one-time payment policy
- Your interest in the one-time payment policy
- Your position and concerns about the policy
- Your opinion about the position and concerns of other stakeholders about the policy
- What you anticipate the prospects and challenges for the implementation of the policy to be.

- And other interesting issues on the one-time payment policy that might come out during our discussion about the above topics

I plan to conduct about 6 FGDs in all. Three of these FGDs would be in this district of which one is for SSNIT contributor (teachers) and one for men and the other for women at the community level. The other 3 FGDs would be conducted in similar way at (NAME) district in the (NORTH or SOUTH) of Ghana. Each FGD is expected to last between 60 to 90 minutes.

Potential risks of your participation

There is very minimal risk of participating in this study. However, since the topic for discussion is about your opinion on the proposed policy, I acknowledge that if the study makes known your opinion to the policy drivers or government, they may tend to have a negative perception of you if your opinion is not in favour of the policy. The study however intends to address this by ensuring that all information gathered from these discussions are treated confidentially and the findings will be presented in a way that you will not be identified by name with your opinion.

There is however, no any anticipated psychological and/or physical stress of participating in this study except that you may have to forgo other activities in order to take part in the FGDs.

Potential benefits for participating in the study

There are no direct material benefits to you as an individual or group for participating in this study. However, since the results will be made available to the National Health Insurance Authority to assist in finalizing the policy, this study offers you a potential platform to make known your opinion on the proposed policy issue. Also, your opinion and that of others, if taken into account by the policy drivers, will increase the possibility of coming out with a health insurance policy that will be widely acceptable to all Ghanaians. Hence your participation in this study offers wider benefits to the Ghanaian society.

Participation and withdrawal

Your participation in this study is voluntary. You can choose either to participate or not to. That is why your involvement in this study has been fully explained and you are asked to freely consent to it. You also have the option to discontinue your participation in the discussion at any time without any adverse consequences.

Is there any other information you will like to know about the study?

Do you agree to participate in the study?

I would also like to add that this study has been granted ethical approval by the Human Research Ethics Committee of the University of Cape Town, South Africa, and the Ghana Health Service, Accra, Ghana (see contact addresses below)

Should you have any questions after the FGD, you are welcome to contact the following:

Gilbert Abotisem Abihiro (Principal Researcher)

University for Development Studies

Faculty of planning and land Management

Post Office Box 520

Wa, Upper West Region, Ghana

[Tel: +233249325818](tel:+233249325818)

gilbiro@yahoo.com

Prof. Diane McIntyre (Supervisor)

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Research and Development Division

Ghana Health Service

Post Office Box MB 190

Accra, Ghana

Tel: +233 0302 681109

Statement of Consent (the one granting consent)

I declare that I have understood all that has been read out and explained to me. I am willing to participate in the study and I therefore grant my concern to participate in the study.

Signature Participant: -----

Date-----

Signature Principal Investigator -----

Date-----

Translator (only applicable to Community level FGDs)

I declare that I read this document to the participant and answered the participants' questions to the best of my knowledge. This conversation was conducted in [enter language].

Signature Fieldworker-----

Date-----

Appendix C: Information for authors: Journal of Health Policy and Planning

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Specific objectives are to:

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- Ensure wide geographical coverage of papers including coverage of the poorest countries and those in transition;
- Encourage and support researchers from low- and middle-income countries to publish in *HPP*;
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- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
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Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:

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A description is required of each author's role in the research process and in preparing the manuscript such as conception and design of the study; analysis and interpretation of the data; and drafting the paper or revising it critically for substantial intellectual content. Authorship is constituted by participating in writing and in one of the other categories. Signed or emailed approval of the submitted paper by all authors is mandatory (a signature or an email from each author). We suggest the following wording for this declaration: "I declare that I participated in the [state contribution/s to the manuscript] and that I have seen and approved the final version. I also declare that I have no conflict of interest in connection with this paper, other than any noted in the covering letter to the editor".

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Appendix D: Budget

Proposed budget for the study

Expenditure Item	Details	Unit cost US\$	Quantity /duration	Amount US\$
Salaries/wages				
Research Assistants (note taker and/or moderator)	1 for 2 weeks (12 days) and 1 for 1 week (6 days) in each district	\$25 per day	36 (18 x 2) days	900
Transcribers	Two transcribers (one for each district)	\$25 per transcript	6 FGDs	150
Translators	To translate consent forms and FGDs guide Twi and Nankam	\$30 per language for each	30 x 4	120
Document reviewer	1 familiar with newspapers in Ghana to comb through all papers to identify papers that have issues on OTTP	\$13 per day	3 days	39
Sub-total				1,209
Equipment				
Stationery	Pens/Pencils	\$4 per box	1	4
	A4 papers	\$10 per ream	1	10
	Field note books	\$4 per unit	6	24
	Folders for holding of documents to field	\$9	3	27
	Thumbprint pad and ink	\$4	1	4
	Staplers and pins	\$5	1	5
Digital voice recorder and accessories		\$200		200
Computer backup device	4GB memory stick	\$19		19
Telecommunication	Phone calls Emails/internet searches			300
Documents in public domain (newspapers etc)	Purchases and/or photocopies of such documents as newspapers with issues on OTTP	\$15		15
Venue for FGDs		\$15 per day	6 days	90
				\$698
Transportation				
Return Air ticket	From Accra to Cape town	\$1,100		1,100
Transportation within	Hiring and fuelling of a motor bike	\$18 per motor	28 day	504

<i>Accra for stakeholder interview</i>	<i>for one month (NK: relatively more expensive rent and use motor in Accra than in districts)</i>	<i>bike per day plus fuel</i>		
<i>Transportation to Districts for FGDs</i>	<i>From Accra to Akwapem South and back (public transport for PI and 2 RAs)</i>	<i>\$15 per person</i>	<i>3</i>	<i>45</i>
	<i>From Accra to Kassena- Nankana District and back ((public transport for PI and 2 RA)</i>	<i>\$80 per person</i>	<i>3</i>	<i>240</i>
	<i>Transportation within districts to conduct FGDs (hiring and fuelling of two motor bites in each district) for 12 days in each district</i>	<i>\$14 per motor bike per day plus fuel</i>	<i>24 days x2 (48)</i>	<i>672</i>
Subtotal				\$2,561
Welfare				
<i>Accommodation</i>	<i>A single bed room to be rented for PI in Accra for Stakeholder interviews</i>	<i>450 per month</i>	<i>1 month</i>	<i>450</i>
	<i>Hotel accommodation for PI and 2 research assistants in Akuapem South (12 days for PI and RA) and 6days for the other RA)</i>	<i>\$13 per day(12 days for each)</i>	<i>12+12+6 =30days</i>	<i>390</i>
	<i>Hotel Accommodation for only 2 research Assistants in kassena Nankan District (6 days for 1 and 12 days for the other)</i>	<i>\$13 per day(12 days for each)</i>	<i>18 days</i>	<i>234</i>
<i>Feeding of two Research Assistants</i>	<i>Research assistants will be provided with meals for two weeks (6 days for 1 and 12 days for the other) in each District</i>	<i>\$13 per day</i>	<i>36 (18 x2) day)</i>	<i>468</i>
<i>Lunch for FGDs</i>	<i>To be provided for all participants at the 6 FGDs (8-12)</i>	<i>\$5 per person</i>	<i>54</i>	<i>270</i>
<i>Reimbursement of transport cost for FGDs</i>	<i>Some FGDs participants would have to either take taxis or fuel their own motor bikes to attend discussion</i>	<i>\$3 per person</i>	<i>54</i>	<i>162</i>
<i>Liaising with community level gatekeepers for community entry and recruitment of FGD participants</i>	<i>Customary gifts for to community leaders and gatekeepers</i>	<i>\$50per district</i>	<i>2</i>	<i>\$100</i>
Sub-total				2,074
<i>Printing , photocopying and binding</i>	<i>Consent forms, data collection instruments and final report</i>			<i>250</i>
Sub-total				250
Grand total				\$6, 792



Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6626 • Facsimile [021] 406 6411
e-mail: lamees.emjedi@uct.ac.za

08 October 2010

HREC REF: 464/2010

Mr G A Abihiro
C/o Prof D McIntyre
Public health & Family Medicine

Dear Mr Abihiro

PROJECT TITLE: UNIVERSAL FINANCIAL PROTECTION THROUGH NATIONAL HEALTH INSURANCE: A STAKEHOLDER ANALYSIS OF A PROPOSED ONE-TIME NHIS PAYMENT POLICY IN GHANA

Thank you for submitting your new study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the FHS HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until 15 October 2011.

Please send us an annual progress report (website form FHS 016) if your research continues beyond the approval period. Alternatively, please send us a brief summary of your findings so that we can close the research file.

With respect to the informed consent for participants in the focus group, please can the research assistants point out that confidentiality cannot be guaranteed since group members may discuss the content of meetings outside the group. However, members can be asked to respect each others' confidentiality.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

Signed by candidate

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

*In case of reply the
number and date of this
Letter should be quoted.*



Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra

My Ref. :GHS-ERC: 3
Your Ref. No.

Tel: +233-0302-681109
Fax + 233-0302-685424
Email: Hannah.Frimpong@ghsmai.org

December 9, 2010

GILBERT ABOTISEM ABIIRO, Principal Investigator

ETHICAL CLEARANCE - ID NO: GHS-ERC: 12/11/10

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"Universal Financial Protection through National Health Insurance: A Stakeholder Analysis of the Proposed One-time NHIS Payment Policy in Ghana"

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification of the project must be submitted to the ERC for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your mother organization before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol

Signed by candidate

SIGNED.....
PROFESSOR ALBERT GEORGE BAIDOE AMOAH
(GHS-ERC CHAIRMAN)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra



UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

Health Economics Unit

School of Public Health & Family Medicine
Faculty of Health Sciences
Anzio Road
Observatory 7925
SOUTH AFRICA
T: (+27 21) 406 6755
F: (+27 21) 448 8152
Director: Dr Susan Cleary

11 November 2010

Dear Sir / Madam

Research being undertaken by Mr Gilbert Abihiro

This letter serves to confirm that Mr Abihiro is registered with our institution for the Masters in Public Health (specialising in Health Economics). We always encourage our Masters participants to undertake their dissertation research in their home country. Mr Abihiro has demonstrated a keen interest in health care financing issues and is focussing his dissertation research on an important current health care financing policy issue within Ghana, the proposed 'one time payment' for the NHIS.

I would be enormously grateful if you could assist Mr Abihiro in his efforts to interview a wide-range of key informants in relation to this health care financing policy, for purposes of his Masters dissertation. We recognise that our request for an interview is an imposition on your very busy schedule, but your support would be greatly valued and would make an important contribution to Mr Abihiro's successful dissertation research. His proposal has been reviewed and approved by the University of Cape Town's Research Ethics Committee. As his dissertation supervisor, I am committed to ensuring that he follows ethical research practices and that he treats the information you provide to him in an ethical way.

Please do not hesitate to contact me at the address below if you require further information.

Yours sincerely

Signed by candidate

Professor Diane McIntyre
South African Research Chair in Health and Wealth

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UNIVERSITY FOR DEVELOPMENT STUDIES
(FACULTY OF PLANNING AND LAND MANAGEMENT)
WA CAMPUS

Tel: 0243 837 281
E-mail: franciszl@yahoo.com

P. O. Box 520
Wa -- UWR
Ghana

Our Ref.: P. 1330

Your Ref.:



17th November, 2010

(Office of the Dean)

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

INTRODUCTION –
MR. ABIIRO GILBERT (P. 1330)

I write to introduce to you **Mr. Abihiro Gilbert** who is a Senior Research Assistant of the Department of Planning of the Faculty of Planning and Land Management.

Mr. Abihiro is pursuing his MPH programme from the University of Cape Town, South Africa and wishes to collect data in your organisation for his research work.

It would be appreciated if you could offer him the necessary assistance he may need.

Counting on your on your cooperation.

Thank you.

Yours faithfully,

Signed by candidate

Fidelis Z. Tang
(Snr. Admin. Assistant)
For: Faculty Officer